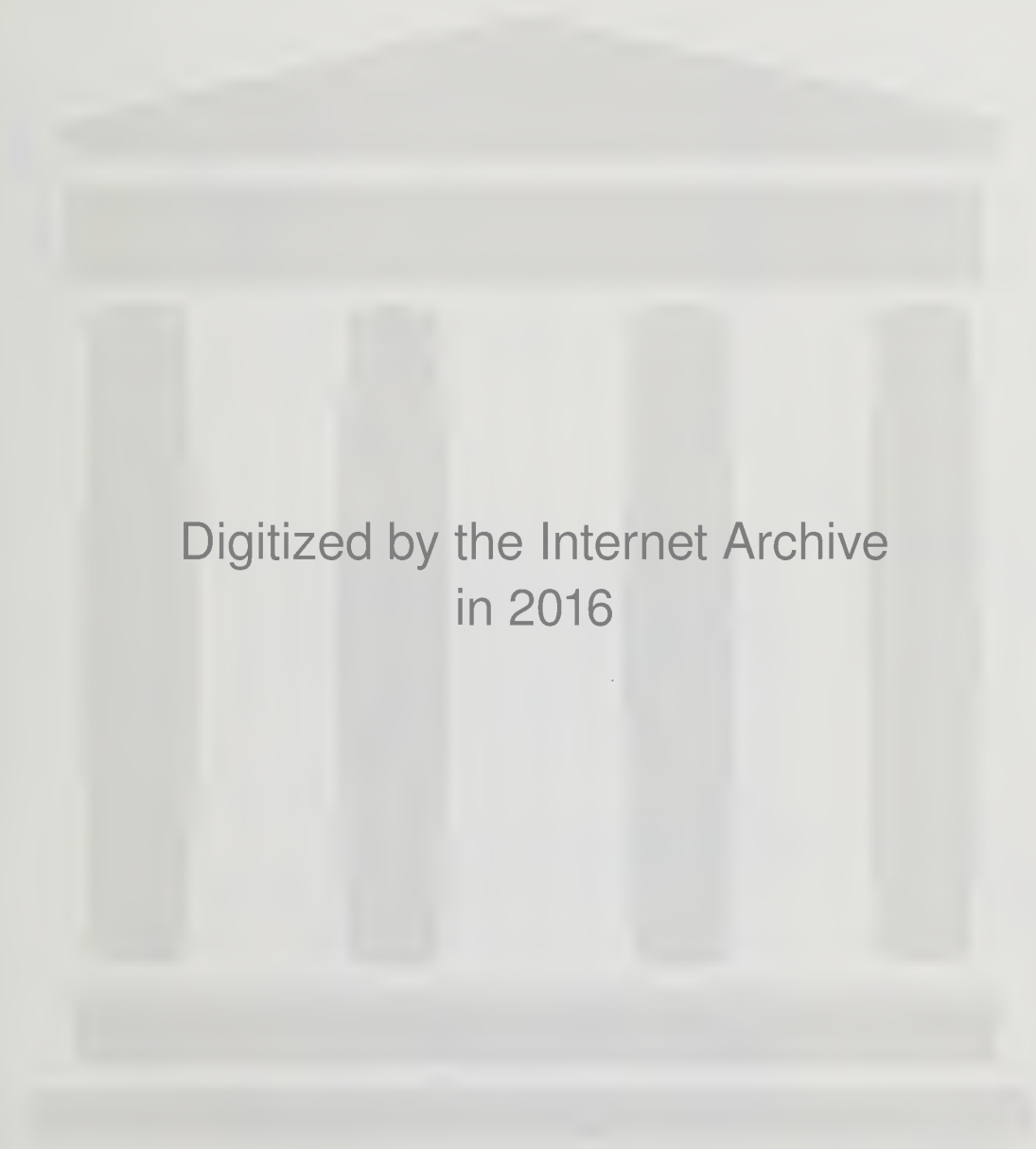
PER

The New York
Academy of Medicine



Gift from the
Publisher



Digitized by the Internet Archive
in 2016

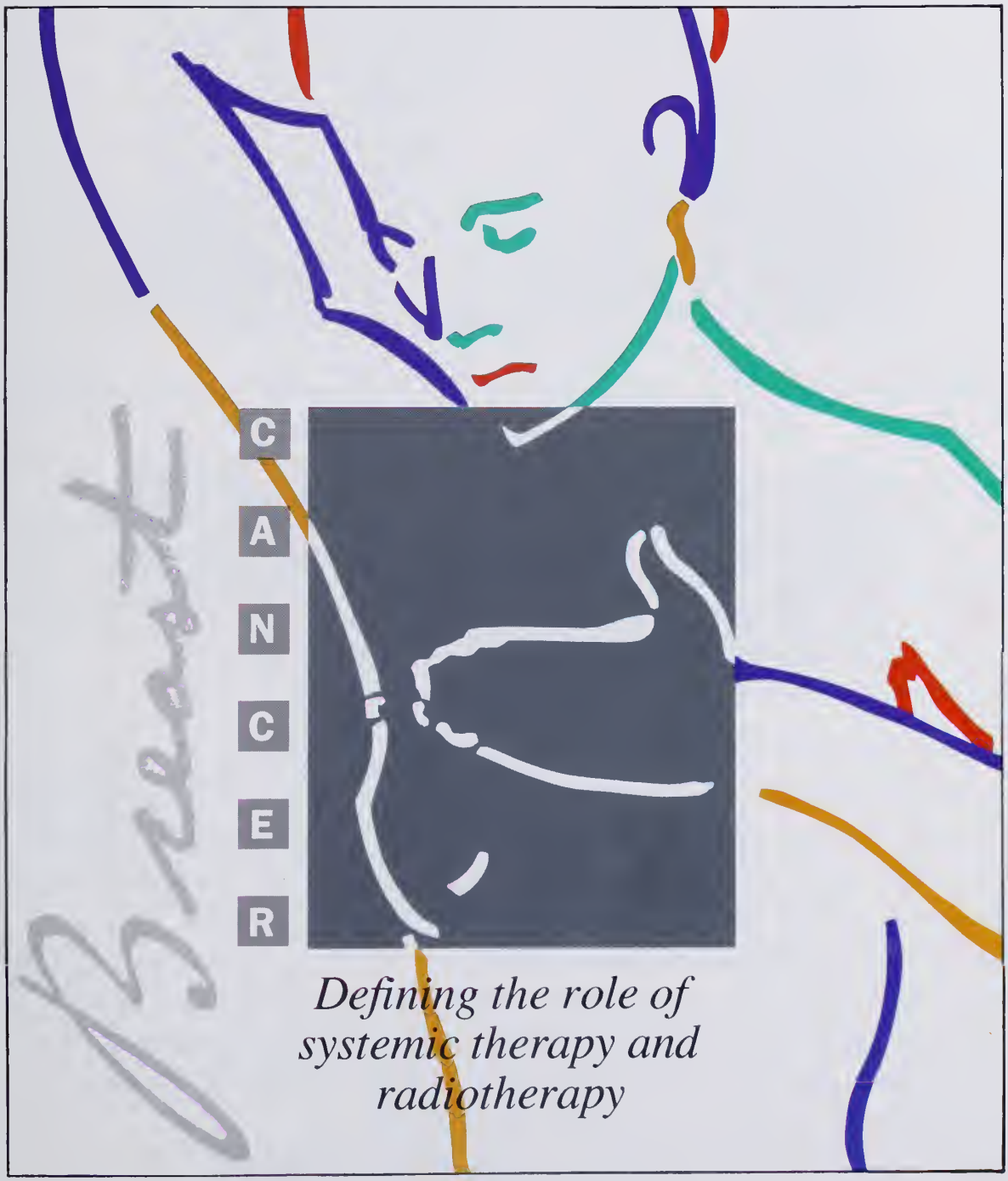
https://archive.org/details/journalofmississ33unse

LIBRARY
APR 1 - 1993
NEW YORK ACADEMY
OF MEDICINE

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JANUARY 1992



Defining the role of systemic therapy and radiotherapy



Bitter. Mad. Hateful. Disappointed. You never know what a day might bring.



That friendly man who answers the phone at MMRC doesn't sound like the same one who showed up 16 years ago at our front door.

A tragic car wreck had left Lamar Myers a quadriplegic. And had left him some pretty bitter feelings to try and deal with.

Fortunately, he wasn't left to deal with them alone. Because the staff at MMRC showed him that life goes on.

"Everybody was willing to work with me," he says. "All I had to do was try. My life didn't have to end the night of that car wreck."

Through months of physical, occupational and recreational therapy, Lamar gained a whole new respect for life. And the staff at MMRC never stopped caring.

It's that commitment to rebuilding patients' lives that makes MMRC the South's leading rehabilitation center. If you don't believe it, just give our switchboard a call.

You'll hear a lot more than a simple "hello" on the other end of the line. You'll hear the voice of a friend who never said goodbye.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JANUARY 1992 VOLUME XXXIII NUMBER 1

SCIENTIFIC ARTICLES

Bacteriology of Middle Ear Effusions 1
C. Ron Cannon, MD, FACS; Bryan M. Clay, MD and Jo Perkins Wilson, MD, FACP

Adjuvant Therapy in Primary Breast Cancer: Defining the Role of Systemic Therapy and Radiotherapy 5
Joseph Salloum, MD

SPECIAL ARTICLE

Health Access Mississippi 11

EDITORIALS

The "Good Ole Days" 20
James C. Waites, MD

Resolve To Be Involved 21
Myron W. Lockey, MD

DEPARTMENTS

From the University of Mississippi Medical Center 24
Medical Organization 25
Meetings Calendar 29
Personals 30
Placement Service 36

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD
Chairman
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
James C. Waites, MD
President
William C. Gates, MD
President-Elect
Don Q. Mitchell, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

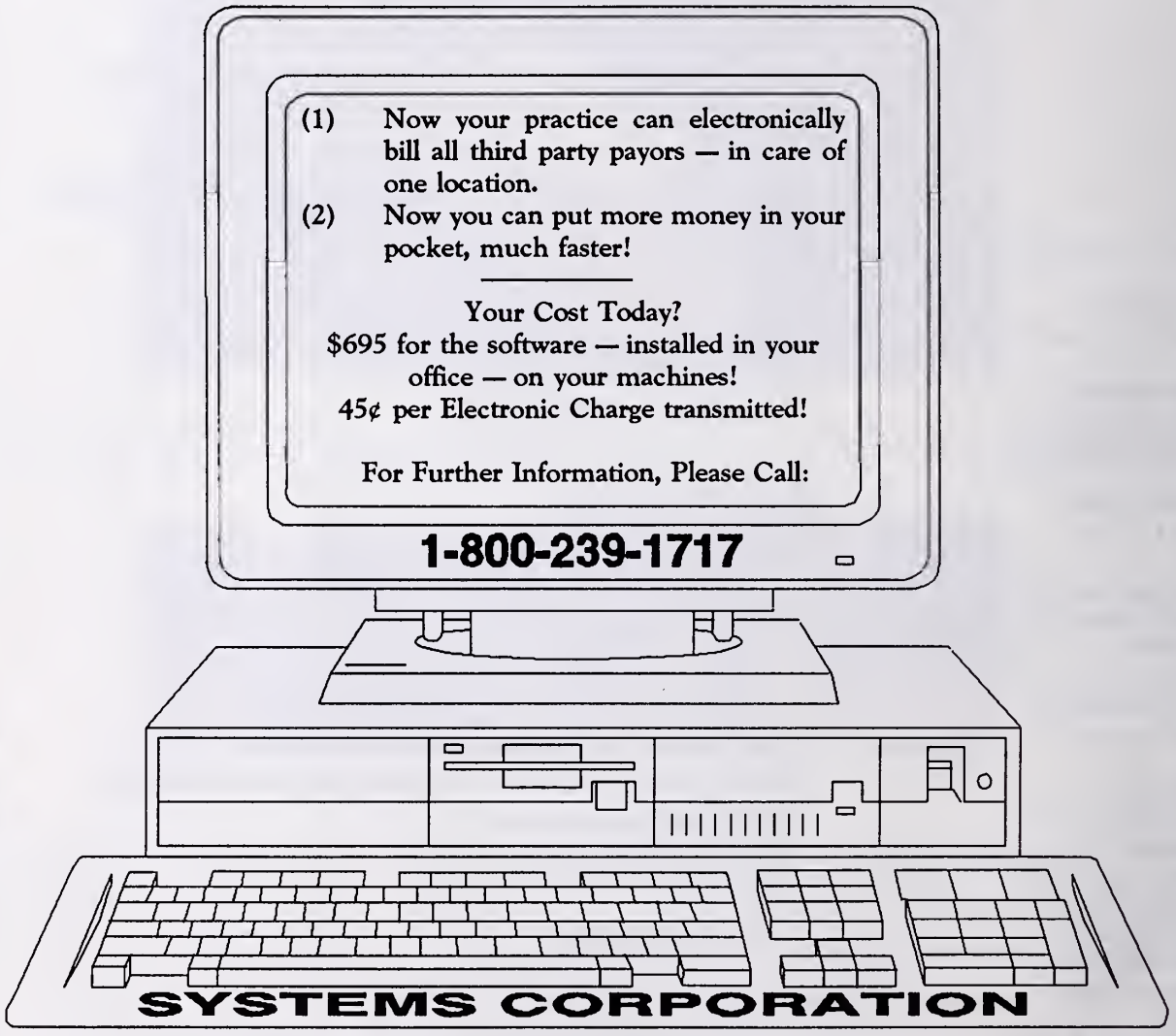
THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.

SYSTEMS CORPORATION

Medical Systems Consultants

Suite 2108, First National Bank Building
Mobile, Alabama 36602
1-800-239-1717
(In Mobile, call 432-1313)

Universal Electronic Billing !



Comparisons

I.	*In 1990, the administrative cost of processing a paper claim approximated $3.50. Utilization of our Electronic Billing System can today reduce costs to $1.50 per claim, approximately.*
II.	*Reimbursement from paper claims can take 7-8 weeks versus 2-3 weeks from Electronic Claims.*

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 1

January 1992

Dear Doctor:

Mississippi physicians have an effective weapon for fighting HIV/AIDS infection: a Mississippi State Department of Health program that provides IV therapy and aerosolized Pentamidine in the patient's home.

But Mississippi physicians aren't taking advantage of the program, said Letitia Collins, care coordinator, HIV/AIDS Prevention Program, MSDH.

The $100,000 program is funded through a Ryan White CARE Grant from the U.S. Department of Health and Human Services.

"The grant provides for preventive as well as end stage therapy," Collins said. "We can provide infusion therapy and aerosolized Pentamidine during any stage of the disease process; it doesn't have to be when the patient is near death."

Collins said a patient's income must be at 200 percent of the federal poverty level to qualify for treatment. Poverty level is determined by the number of family members the patient is supporting or helping to support.

The program accepts patient referral from anyone in the medical community, but patient treatment can't begin without a physician's order. The patient must have diagnosed opportunistic disease related to HIV infection that requires IV therapy. The patient doesn't have to be homebound, but the patient's care must be limited by geographical or physical conditions.

"The IV therapy doesn't have to be for pain or rehydration," Collins said. "We can provide anti-viral, anti-bacterial, or any other infusion therapy the physician recommends."

For a patient to receive the aerosolized Pentamidine, he must have a T4 cell count of 200 or less or have had an episode of PCP (*Pneumocystis carinii* pneumonia).

Any licensed home health agency is the state can provide this specialized patient treatment once they meet the grant requirements for providers. Average cost per patient per month can reach about $1,900, which provides skilled nursing care, equipment rental, and drugs.

"This program is strictly for infusion or aerosolized therapy," Collins said. "The grant doesn't pay for aides to clean the home or help the patients with bathing or other personal care services."

Collins said it usually takes about two weeks from the date the program receives the physician's orders for the patient to start receiving services. Some rural areas or other areas without established providers may take more time before treatment can begin.

"We don't have a waiting list right now, and we're providing therapy to only nine Mississippians," Collins said. "We really want physicians to take advantage of the program for their patients. Many of the patients don't have hospital insurance and aren't on Medicaid, and this is therapy that could greatly improve their quality of life."

The HIV/AIDS Prevention Program continues to provide drugs through a separate but well-utilized plan, the AIDS Drug Reimbursement Program.

For more information about these programs, contact Letitia Collins, HIV/AIDS Prevention Program, 960-7723.

THE UNITED STATES ARMY RESERVE

HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

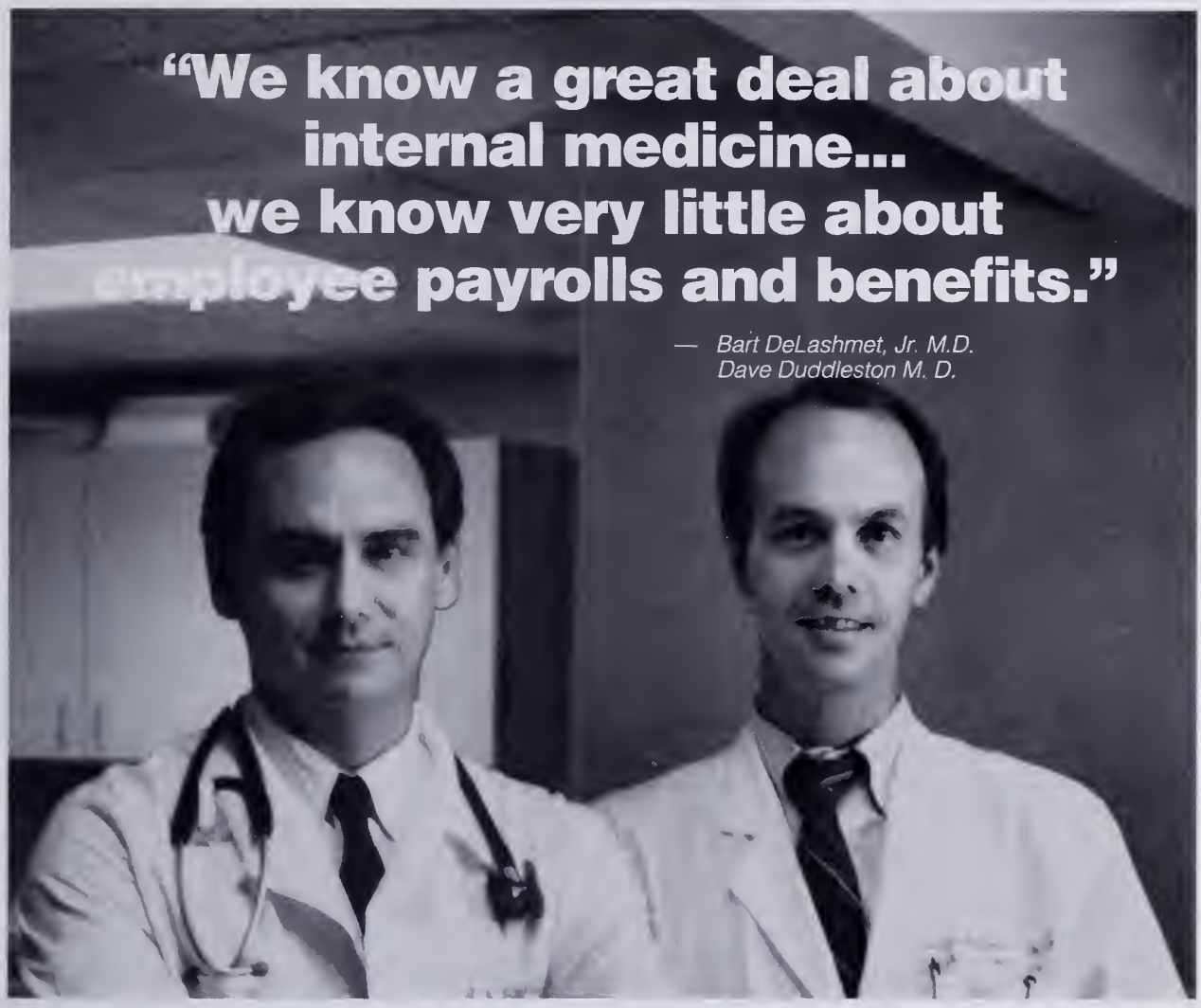
BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727



Specialization.

In today's professional environment, it pays to concentrate one's energies in the areas of one's expertise.

So, when Dr. Bart DeLashmet, Jr. and Dr. Dave Duddleston, *specialist* in internal medicine and partners in the Central Medical Clinic, made the decision to contract with Employer Plus, they showed an appreciation of someone else's area of *specialization.*

They recognized what more and more small business executives and professional acknowledge: in hiring Employer Plus, a firm that *specializes* in employee payroll and benefits management and other employee administrative matters, they could save time, money and aggravation. Also, they could offer their employees a more complete package of benefits, including a cafeteria plan. And, satisfied employees make longer lasting employees.

Just as the doctors, nurses and staff of the Central Medical Clinic focus their attention on the practice of internal medicine, Employer Plus concentrates its efforts on employee management.

If you have a sick feeling that you are spending too much time on non-productive administrative task and not enough time on your practice, call Employer Plus, today.

We've got the right prescription.

In fact, we're just what the *doctors* ordered!

Employer Plus, Inc.

4537 Office Park Drive • P.O. Box16283
Jackson, MS 39236-6283 • (601) 366-7293 • 1-800-844-0093

*No one administers payroll and employee benefits, better!*SM

©1991 Employer Plus, Inc. All rights reserved



Partners In Health Care

Mississippi's public health system and Aaron E. Henry Health Center; Eliya George Abbud; Bonda Abide; Michelle D. Abram; Thomas Adams; Amornrat Aftandilian; Tim Alford; J. R. Beckham; Sidney Bondurant; Luis V. Borrell; William Bradford; Bert Bradford; Robert B. Brahan; Brookhaven OB/GYN Associates; Thomas J. Brooks, Jr.; Edward Bryant; James M. Cade; Floyd T. Carey; Richard C. Carter; Central Orthopedic Clinic; Children's Cardiac Consultants; Cherry Clark; Billy Collum; David A. Compton; Douglas Conner; David Conwill; Edmund H. Crane; Virginia Crawford; A. Dean Cromartie; Deborah Downing; Owen Bev Evans; Sandor Feldman; James W. Fite; Joel Flynt; Francis F. Fountain; Robert Gannaway; Pat Gill; H. Lamar Gillespie; Hilton L. Gillespie, Jr.; A. Lamar Glaze; Virginia Green; Marion V. Green; J. S. Haney; Stanley Hartness; Delores Hatcher; Hattiesburg Clinic Professional Association; Health First Medical; Kenneth Hines; Rebecca Hodges; M. L. Hogan; Thomas E. Holden; Gary D. Holdiness; Edward H. Holmes; W. Briggs Hopson; Patrick S. Hsu; David R. Hubbs; Internal Medicine Associates; Robert B. Ireland, Jr.; Paul Jackson; A. J. Jackson; John R. Jackson; J. T. Janes; J. Darrell Jee; Walter Johnston; James Joransen; Ralph C. Kahler; William Kahlstorf; Allen Karstens; Elizabeth O. Keeling; Carolyn Kergosien; Isaac C. Knox, Jr.; Ronald Krueger; Ledon Langston; James Caulifield Leak; John H. Long; Lawrence Mahalak; Carole Mangrem; W. T. Mayer; James R. Mayfield; Hilda McGee; Obie McNair; Jack A. McNeil; U. J. Mehta; Meridian Medical Associates; Johnny F. Miles; Joseph R. Mitchell; Walter Moody; David B. Moore; Frank J. Morgan; Walter C. Moses, Jr.; Mississippi Urology Clinic; Teresa Mulvihill-Byers; North Mississippi Neonatology; David Mulholland; L. J. Owens; Oxford OB/GYN Associates; W. L. Pace; Matthew J. Page; Shanti Pandey; Colette C. Parker; Charles Parkman; William D. Payne; Cheryl. L. Perkins; E. J. Price; James F. Puckett; Purnima R. Purohit; Natalie B. Reddix; William F. Reid; Cirila Reyes; Warren F. Ricchetti; William Riecken; Charles Rinker; Charles Robertson; Benjamin Sanford; Arlillian Savare; Cathy Sessums; E. L. Shannon; John Shields; Sue H. Simmons; Samer Siouffi; Charles C. Sledge; M. Shelby Smith; J. Clinton Smith; Starkville Clinic for Women; Stat Physicians, Inc.; Ray Stewart; Edsel Stewart; Reuben H. Stone; A. W. Tannehill; Patrick E. Tarpy; Douglas F. Thomas; Barry F. Tillman; D. G. Townsend; Betty Turner; Jackey D. Turner; University Physicians; Cynthia Voelker; Frank Voelker; Raymond Wait; Tom Walker; Lynn Walker; Rosie L. Walker-McNair; Frazier Ward; Glen C. Warren; Chris Waterer; Billy N. Watkins; David Watson; Jerry W. Welch; Peggy Wells; T. E. Westbrook; Roy C. Wigginton; J. Collins Williams; Jo P. Wilson; Arthur Wood, Jr.; John D. Wofford.

Together, we can!

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

Bacteriology of Middle Ear Effusions

C. RON CANNON, MD, FACS
BRYAN M. CLAY, MD
JO PERKINS WILSON, MD, FACP

Otitis media with effusion (OME) is one of the most common diseases of childhood. Fifty percent of children have OME during the first year of life, and nearly seventy percent have middle ear disease by age two. If left untreated serious sequelae such as meningitis, brain abscess, and other intracranial supporative complications may occur. Long term sequelae such as delay in speech development, learning problems, or permanent hearing loss may result from OME. Recommended treatment for OME begins with antibiotic therapy and may eventually involve myringotomy with insertion of ventilation tubes.

Several different pathogens have been cultured from middle ear effusions in previous studies. The purpose of this study is to identify the bacteria in middle ear effusions (MEE) at time of myringotomy, the antibiotic susceptibility pattern of the pathogens, and any relation of bacteriologic patterns to effusion type. Recommendations for medical therapy will be concluded from these data.

Material and Methods

A total of fifty-three children underwent bilateral myringotomy and insertion of teflon ear tubes over a six month period from October 1989 to April 1990 at two hospitals in Jackson, MS. These patients were referred by local physicians for surgical evaluation of OME with greater than three months duration or more than three to four episodes within a six month period. Only patients with MEE documented by tympanometry during the above period were selected for the study. None of these children had tympanostomy tubes at the time of surgery. Eighty-one percent of the patients were taking antibiotics at the time of surgery (see Table I).

Table I. - Antibiotic Therapy Prior To Surgery (# of Patients Taking Antibiotics - 42)

Antibiotic	Number Pts	%
Amoxicillin	2	4.8%
Amoxicillin/Clavulanate	5	11.9%
Cefaclor	18	42.9%
Cefixime	8	19.0%
Cefotaxime	1	2.4%
Ceftriaxome*	2	N/A
Erythromycin Ethylsuccinate & sulfisoxazole	4	9.5%
Trimethoprim/Sulfamethoxazole	4	9.5%

* Taken in combination with other antibiotics

Prior to surgery temperature and white blood cell count were recorded. After obtaining adequate general anesthesia and removing any cerumen from the external auditory canal, a myringotomy was made in the anterior inferior or anterior superior quadrant of the tympanic membrane. Using a sterile Lukens trap, the MEE was immediately aspirated into individual containers for left and right ears and sent to the microbiology lab for routine aerobic and anaerobic cultures. Effusions were classified as serous or mucoid with a purulent or non-purulent qualifier. Following aspiration teflon ear tubes were inserted and three drops of gentamicin sulfate solution were place in each external auditory canal. Culture results were

considered final at seven days.

Results

Fifty-three patients were included in the study. Ages ranged from four months to nine years with a mean of 21.2 months. Twenty-three patients (43%) were aged 4 to 12 months, while 24 (45%) ranged from 13 to 36 months. The remaining six patients (11%) ranged from 37 months to 9 years. Twenty-two patients (41.5%) were females and thirty-one (58.5%) were males.

Forty patients had bilateral effusions and thirteen had unilateral effusions. A total of ninety-three effusions were cultured. Thirty-two effusions (35%) were classified as serious with twenty of these being purulent and twelve being non-purulent. Sixty-one effusions (65%) were mucoid with nineteen of these being purulent and forty-two being non-purulent.

Fifty-one percent (20) of all purulent effusions had positive bacterial cultures. Purulent serous effusions accounted for twelve of these twenty, whereas purulent mucoid effusions accounted for only eight. Twenty-six percent (16) of mucoid effusions and thirty-eight percent (12) of serous effusions respectively grew pathogens. Only one patient had temperature greater than 100° F, and one patient had an elevated white blood cell count.

Overall twenty-eight of ninety-three effusions (30%) were culture positive (see Table II). Three cultures were positive for two organisms, *Streptococcus pneumoniae* and alpha hemolytic streptococci in each case. *Streptococcus pneumoniae* and *Haemophilus influenzae* were the most frequently isolated organisms from the MEE with twelve isolates each. *Staphylococcus aureus* was isolated from two effusions as was *Branhamella (Moraxella) catarrhalis*. Three cultures were positive for *alpha hemolytic streptococci*. No anaerobic bacteria were isolated. Susceptibilities of *Streptococcus pneumoniae* revealed only two strains resistant to penicillin. Four strains of *H. influenzae* and one strain of *B. catarrhalis* were Beta lactamase positive and therefore resistant to penicillin G, amoxicillin, or ampicillin.

Table II. - Bacteriology of Culture Positive Effusions

Pathogen	Number	%
Haemophilus influenzae	12	42.9%
Streptococcus pneumoniae	12	42.9%
*Alpha hemolytic streptococcus**	3	10.7%
Branhamella (Moraxella) catarrhalis	2	7.1%
Staphylococcus aureus	2	7.1%

* Found in combination with *S. pneumoniae* on three cultures.

Comment

These results reveal that viable bacteria are present in MEE at time of myringotomy for otitis media with effusion despite treatment with antibiotics at the time of surgery and in many cases for a long time prior to surgery. Our culture rate of thirty percent might have been even higher had we eliminated children recently on antibiotics as Calhoun et al suggest[1], but even so vividly demonstrates the fact that antibiotics do not always sterilize MEE even when the patient shows no signs of toxicity. Even so, this positive culture rate falls within the 24% to 50% positive culture rate of previous studies.[2,3] The majority of isolates included *S. pneumoniae, H. influenzae,* and *B. catarrhalis* which are commonly regarded as pathogens in OME. Our population demonstrated a somewhat higher percentage of *S. pneumoniae* (42.9%) than other studies such as one by Diamond et al, where *S. pneumoniae* accounted for only sixteen percent.[4] *S. aureus*, which was isolated from two effusions, is known to be a causative agent in OME, but occurs infrequently according to Kurono et al.[5] Our findings were quite similar to Bluestone in his review of 1,432 middle ear cultures. He found 44% *S. pneumoniae*, 31% *H. influenzae*, 17% *Branhamella catarrhalis*, and 2% *S. aureus*.[6]

It is interesting to note that no anaerobic organisms were isolated from the MEE. This is consistent with a study by Diamond, et al, in which less than one percent of positive cultures were anaerobes, and those where in conjunction with a cholesteatoma.[4]

It would be difficult to relate effusion type to positive cultures based on our data. Nearly equal percentages of positive cultures were obtained when comparing mucoid and serous effusions (26% and 38%, respectively). Purulent effusions comprised nearly equal percentages of positive cultures as negative cultures (51% vs 49%). A previous study comparing effusion types to pathogenesis also found that there was no relation between these two variable.[7] As only one patient in our study had a temperature or white blood cell count greater than the normal range, we were unable to relate positive culture rates to these variables. Thus the decision to culture a MEE should be based on clinical parameters of the patient's clinical course rather than the nature of the effusion alone.

Our study reveals a low incidence of penicillin

resistant *S. pneumoniae* or Beta lactamase positive *H. influenzae* and *B. catarrhalis*. Amoxicillin or ampicillin would adequately treat approximately seventy percent of OME in our patient population and should still be considered the initial treatment of choice for OME. Other authors support that idea that amoxicillin is adequate therapy for OME in areas with low Beta lactamase producing *H. influenzae* and *B. catarrhalis*.[8] Cephalosporins such as cefaclor, cefuroxime-axetil, and cefixime are active against Beta lactamase positive *H. influenzae* and *B. catarrhalis* as well as *S. pneumoniae*. Alternatives for treatment include amoxicillin-clavulanate, erythromycin and sulfisoxazole combination, or trimethoprim/sulfamethoxazole all of which would cover the resistant and Beta lactamase positive organisms. If these medical methods fail to resolve OME over a period of two to three months, then myringotomy with placement of ventilation tubes is the next logical step.

Conclusion

Viable bacteria are present in MEE at time of myringotomy for ventilation tube placement even after numerous courses of antibiotic therapy. *S. pneumoniae* and *H. influenzae* remain the most common but not exclusive organisms cultured from MEE. Anaerobic organisms do not seem to play a significant role in OME. Effusion type cannot be used as a reliable predictor of positive culture results, nor can temperature or white blood cell count. Our culture results indicate that amoxicillin or ampicillin can still be used with a good degree of clinical efficacy and should be considered drugs of choice in initial therapy.□

PO Box 5345
Jackson, MS 39296-5345

References

1. Calhoun KH, Norris WB, Hokansson JA, Stiernberg CM, and Quinn FB. Bacteriology of middle ear effusion. *South Med J*. Mar 1988;81:332-336.
2. Sriwardhana KB, Howard AJ, and Dunkin KT. Bacteriology of middle ear effusion. *J Laryngol Otol*. Mar 1989;103:253-256.
3. Healy GB and Teele DW. The microbiology of chronic middle ear effusions in children. *Laryngoscope*. Sept 1977;87:1471-1478.
4. Diamond C, Sisson PR, Kearns AM, and Ingham HR. Bacteriology of chronic otitis media with effusion. *J Laryngol Otol*. Apr 1989;103:369-371.
5. Kurono Y, Tomonaga K, and Mogi G. Staphylococcus epidermidis and Staphylococcus aureus in otitis media with effusion. *Arch Otolaryngol Head Neck Surg*. Nov 1988;114:1262-1265.
6. Bluestone, CD. Management of otitis media in infants and children: current role of old and new antimicrobial agents. *Pediatric Infectious Diseases Journal*. Nov 1988;7:S129-136.
7. Giebink S, Chap TL, and Paparella MM. Epidemiology of otitis media with effusion in children. *Arch Otolaryngol*. Sept 1982;108:563-566.
8. McCraken GH. Selection of antimicrobial agents for treatment of acute otitis media with effusion. *Pediatric Infectious Disease Journal* Oct 1987;6:985-988.

Dr. Cannon is in the private practice of Otolaryngology, Surgery, Head and Neck, Jackson, MS; Dr. Clay is a surgical intern in Memphis, TN and Dr. Wilson is in the private practice of internal medicine, Jackson, MS.



You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

Adjuvant Therapy in Primary Breast Cancer: Defining the Role of Systemic Therapy and Radiotherapy

JOSEPH SALLOUM, MD

Increasing numbers of prognostic variables have been identified that define the natural history of breast cancer. These include the histologic status of axillary lymph nodes[1], primary tumor size[2], steroid hormone receptors, menopausal status or age, histopathology and more recently aneuploidy and proliferative index. The pathologic status of the axillary lymph nodes remains the single most important prognostic variable. Adjuvant therapy is claimed to eradicate occult metastatic disease and prolong survival. The objective of this study is to evaluate the effect of adjuvant therapy in patients with breast cancer at high risk of recurrence and relapse of their disease.

METHODS AND MATERIALS

We reviewed all the cases of breast cancers with positive axillary nodes (N_1) or primary tumors above 5 cm that were entered into our Tumor Registry between January 1984 and December 1987. Ninety-one patients met these criteria and their T, N, M stages[3] are shown in Table I.

All patients underwent a modified radical mastectomy as primary mode of therapy. Sixty-seven patients (73%) underwent adjuvant systemic therapy. Thirty-seven patients had chemotherapy, 20 patients had hormonal therapy and 10 had both. Also 10 patients underwent adjuvant local radiotherapy (9 with chemotherapy, 1 with hormones). Twenty-four patients did not receive adjuvant therapy. The minimum follow-up was 36 months.

Stage II	T_1 , N_1	11
	T_2 , N_1	61
Stage III A	T_3 , N_0	7
	T_3 , N_1	8
Stage III B	T_4 , N_1	3
	T_4 , N_3	1

Table I

Number of Nodes	Disease Free Survival	Overall survival	Disease Specific Survival
N_0 (T_3)	83 %	83 %	100 %
1 - 3	55 %	74 %	79 %
4 - 9	44 %	53 %	56 %
> 10	13 %	27 %	33 %

Table II

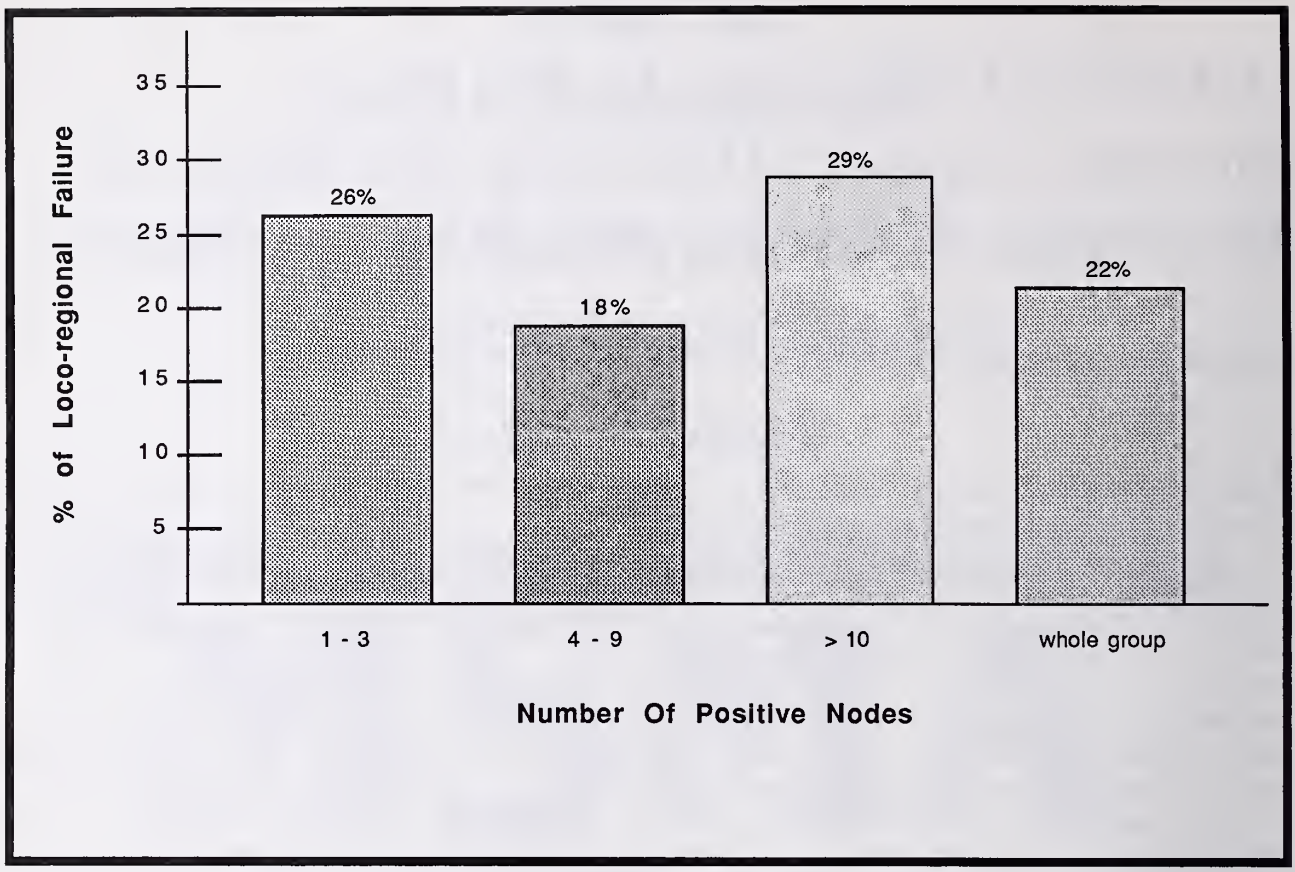


Figure I

RESULTS

The overall survival of the whole group (as of 12/90) was 59% (54/91). The disease specific survival was 65% (59/91 - 5 patients died without evidence of disease). The disease free survival (DFS) was 46% (42/91). The survival was directly related to the number of positive axillary nodes (see Table II).

Locoregional Failure

There were 22 locoregional failures for an incidence of 24%. The sites of failure were as follows: chest wall 16, axilla 2 and supraclavicular nodes 4. Two patients had both chest wall and nodal failures. Accordingly the actual incidence of locoregional failure was 22% (20/91). The incidence of locoregional failure by the number of axillary lymph nodes involves is demonstrated in figure I.

Nine of the 20 patients who developed locoregional failure received adjuvant chemotherapy after mastectomy, four received hormonal therapy and two received adjuvant radiation therapy. Eleven of these patients (55%) have subsequently developed distant failure. The three year survival of this group of patients was 45%.

Distal Failure

The incidence of distal failure was 40% for the whole group (36/91). Forty-two percent of patients who received adjuvant chemotherapy or hormones developed distant metastasis (38/66). The incidence of distal failure in the smaller group of patients who did not receive adjuvant therapy was 46% (11/24). Table III compares the survival of the group of patients who received adjuvant therapy to the group who did not.

DISCUSSION

Our review of this group of patients with breast cancer demonstrated and confirmed the advantage of adjuvant systemic chemotherapy in this risk group. There was a significant improvement in the disease free survival in the treated group when compared to the untreated group 49% versus 25%.

Adjuvant therapy had a significant impact on reducing locoregional recurrence. This was 42% inpatients who did not receive adjuvant therapy, but dropped

	Adjuvant Therapy	No Adjuvant Therapy
Disease Free Survival	**49 %**	**25 %**
Overall Survival	**64 %**	**38 %**
Disease Specific Survival	**67 %**	**54 %**

Table III

to 17% with adjuvant therapy. In the small group of patients who received both adjuvant chemotherapy and local radiotherapy the local recurrence was 10% (1/10); this patient had a T4 lesion (metastatic skin nodules) and 14 out of 22 nodes positive. The current findings are similar to the results of a large series of patients with breast cancer treated at the M.D. Anderson Cancer Center (768 patients).[4] The rates of locoregional recurrence were 12% for patients receiving chemotherapy (FAC) only and 5% for patients received FAC plus XRT.

CONCLUSIONS

I. The axillary node status continues to be the most important prognostic factor in breast cancer.

II. Adjuvant systemic therapy should be recommended to all patients with node positive breast cancer as it improves the disease free and overall survival. Also results from two NSABP randomized clinical trials B-13 and B-14 demonstrated a benefit from adjuvant systemic therapy in patients with node negative breast cancer.[5] There was a prolongation of disease free survival with adjuvant chemotherapy in estrogen-receptor negative tumors and with Tamoxifen in estrogen-receptor positive tumors.

III. Post mastectomy irradiation significantly reduces the locoregional recurrence rate. However, its role is getting to be controversial because of the widespread use of adjuvant chemotherapy. It is reasonable to withhold radiation therapy when adjuvant chemotherapy is being administered in patients with fewer than three positive axillary lymph nodes and without grave signs of primary tumor or regional nodes. However, patients who fall into high risk categories should receive irradiation to the chest wall and peripheral lymphatics in addition to adjuvant chemotherapy.[6]

The high risk features are:

1. Four or more positive axillary nodes
2. Lesions greater than 5cm in diameter
3. Invasion of tumor to skin or pectoral fascia
4. Tumor permeation of dermal lymphatics
5. Multicentric disease

The Milan II Study[7] had confirmed that six months of CMF were as effective as twelve months. Thus, one may consider delivering six cycles of adjuvant chemotherapy prior to irradiation. Interdigitation of Tamoxifen and irradiation is not as complex as with chemotherapeutic agents, as concurrent administration of Tamoxifen and radiation is well-tolerated. ❑

5000 West Fourth Street
Hattiesburg, MS 39402-6030

References

1. Fisher B, Wolmark N, Bauer M, et al. The accuracy of clinical nodal staging and of limited axillary dissection as determinant of histological nodal status in carcinoma of the breast. *Surg Gynecol Obstet*. 1981;152:765.
2. Donegan WL, Perez-Mesa CM, Watson FR. A biostatistical study of locally recurrent breast carcinoma. *Surg Gynecol Obstet*. 1966;122:529.
3. American Joint Committee on Cancer: Manual for Staging of Cancer, 3rd Edition, Philadelphia, JB Lippincott Co.,1988.
4. Buzdar A, McNeese M, Ellenbroek N, et al. Is chemotherapy effective in reducing the local failure rate in patients with operable breast cancer?*Cancer*. 1990;65:394-399.
5. Fisher B, Wickerham L, Wolmark N, et al. Systemic therapy in patients with node negative breast cancer. *Ann Intern Med*. 1989;III:703-712.
6. Primary Therapy of Breast Cancer Study Group: Identification of breast cancer patients with high risk of early recurrence after radical mastectomy: II. Clinical and pathological correlation. *Cancer*. 1978;42:2809.

7. Bondadonna G, Valagussa P, Rossi A, et al. Ten-year experience with CMF-based adjuvant chemotherapy in resectable breast cancer. *Breast Cancer Res Treat.* 1985;5:95-115.

***Dr. Salloum** is associated with the Hattiesburg Radiology group. This information is from the Hattiesburg Cancer Program and Tumor Registries of Forrest General and Methodist Hospitals, Hattiesburg.*

Rural Health
CARING
for the country

National Rural Health Association
15th Annual Conference on Rural Health
May 6–9, 1992
Hyatt Regency Crystal City
Washington, DC



RUN A SPECIAL PRACTICE.

Today's Air Force has special opportunities for qualified physicians and physician specialists. To pursue medical excellence without the overhead of a private practice, talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay each year that are part of a medical career with the Air Force. Discover how special an Air Force practice can be. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

IT TOOK YOU MANY YEARS TO BECOME A PHYSICIAN...

MPIC

Mississippi State Medical Association Sponsored Insurance Plans

Why spend one more minute looking for LIFE INSURANCE?

The Mississippi State Medical Association, Manhattan National Life, and BellMED Insurance Resource Center Inc., have joined together to offer MSMA endorsed SIMPLIFIED ISSUE Term Life plans. Our current SUPERSAVER XV long term, low cost plan offers MSMA members, their staff and spouses these benefits...

★ **GUARANTEES**

— In these days of economic and financial uncertainty, we are pleased to offer you a 15 YEAR RATE GUARANTEE

— Your premium stays level and cannot be increased for the next 15 years...and that's guaranteed

— The coverage is guaranteed renewable to age 95

★ **SIMPLIFIED ISSUE**

— NO EXAM or BLOODWORK*

— NO SALESPERSON VISIT

— ONE PAGE APPLICATION

★ **VERY LOW RATES**

— example: $200,000 preferred non-smoker — annual rate guaranteed for 15 years

Age 40	=	**$400**
Age 45	=	**$554**
Age 50	=	**$800**

IF YOU HAVE ALREADY TAKEN ADVANTAGE OF THE PROGRAM...*THANK YOU!*

BELLMED

If you have not, we think SIMPLIFIED ISSUE SuperSaver XV makes sense. For rates and information, call BellMED at

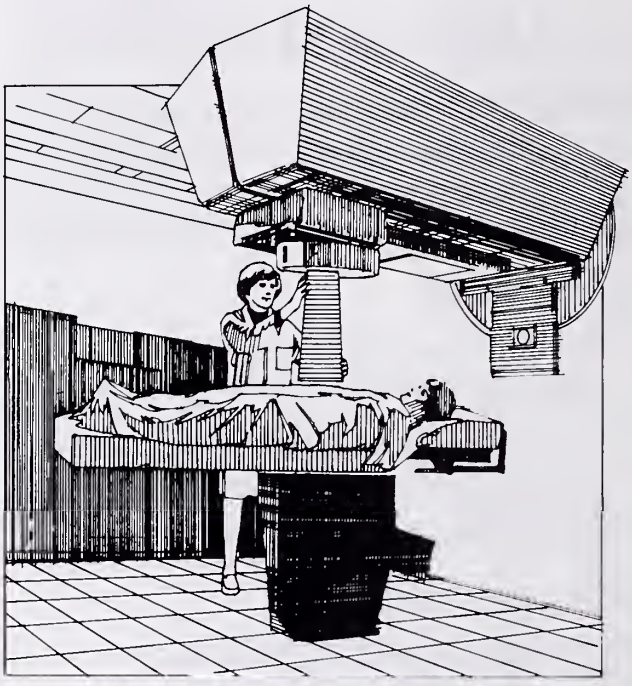
1-800-456-8042

Manhattan National Life

*Manhattan National Life does reserve the right to request additional information.

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Health Access Mississippi

The American health care system provides the highest quality medical care in the world. Unfortunately, for some Americans access to this system is limited, and every American should have access to essential health care.

As the cost of medical care has risen, affordability has become a central issue. Medical insurance has become more costly, and the number of uninsured people has increased. Access to health care has become a major concern for Mississippians.

Some areas of our state lack the medical personnel and resources necessary to provide essential medical services. In particular, the availability of obstetrical care in rural areas is especially critical.

The Mississippi State Medical Association (MSMA) recognizes that problems exist in our health care system. In response, MSMA has developed Health Access Mississippi, a comprehensive plan to improve access to quality, affordable health care in the state of Mississippi.

We recognize that no single plan will rectify all of the problems that society faces in its efforts to deliver quality health care. It is hoped that Health Access Mississippi will serve as a stimulus for further discussion and planning in assuring quality health care for all of our people.

THE SITUATION

The problem of availability of health care in Mississippi is mostly attributable to three factors: **the large number of persons who have no public or private health insurance coverage, the shortage of health manpower in many areas of the state, and the increasing cost of health care services.**

THE UNINSURED

Approximately 18% of Mississippi's population is without any kind of health insurance, either public or private. This is much higher than the 13% of the total U.S. population that is uninsured.

Of the roughly 475,000 Mississippians who do not have health insurance, 330,000 (70%) are between the ages of 18-64. Approximately 58% of these uninsured non-elderly adults are employed. Again, this is noticeably higher than the 53% of employed persons nationally who are uninsured.

The number of Americans with private health insurance coverage more than doubled between 1950 and 1965 when the Medicare and Medicaid programs were enacted. Since that time the growth in insurance coverage has slowed and even declined in the 1980's from 80% to 76% of the population. While 62% of Americans have employment based health insurance coverage, only about 50% of Mississippians are insured through their place of employment.

The decline in the number of persons with health insurance coverage is difficult to explain, but there is general agreement that it is largely due to the fact that more companies are not providing insurance coverage as an employee benefit and, if offered, more workers are declining to maintain such coverage. Both possibilities are probably related to the increasing cost of health insurance coverage and the overall escalation of health care costs.

THE SHORTAGE OF HEALTH PROFESSIONALS

Mississippi ranks last of all the states in the number of physicians per 100,000 population. The physician-to-population ratio is more acute in non-metropolitan rural areas of the state. Thirty-nine of our 82

counties have been designated as **"Health Professions Shortage Areas"** by the U.S. Department of Health and Human Services.

The availability of obstetrical services in rural areas of Mississippi is particularly critical. The 222 obstetricians in the state are located in only 31 of our 82 counties. Between 1983 and 1990 the number of hospitals providing obstetrical and newborn services declined from 97 to only 51. More importantly, of the approximately 700 general and family practitioners throughout the state, only about 50 are providing obstetrical services. Ten years ago four times as many such physicians were delivering babies throughout the state.

The decline in obstetrical services is principally due to both the high number of Medicaid, reduced fee and charity deliveries and the high cost of medical malpractice insurance associated with the provision of obstetrical care.

The problem of attracting and retaining physicians to rural areas is multifaceted. Access to new technology, the lack of after-hours and weekend coverage by other physicians, a lack of continuing educational opportunities and family considerations are but a few of the many reasons why new and young physicians decline to locate in such areas. In Mississippi, these problems are further exacerbated by simple economic considerations driven by the inordinately large number of uninsured, Medicare and Medicaid patients residing in non-metropolitan areas of the state.

About 14% of Mississippians are covered under the Medicare program for the elderly, while another 18% are covered by the Medicaid program for the low income population. This combined 32% of the population, when added to the 18% who have no insurance of any kind, means that half of the state's entire population has no health insurance or is covered by one of the two federal programs whose payments average anywhere from 30-70% of what a physician normally charges. The total percentage of Mississippians without health insurance or who are covered by Medicare or Medicaid is even higher in rural areas of the state, making it even more difficult to operate a medical practice under such conditions. Mississippi physicians receive the lowest Medicare reimbursement rate in the country; Medicaid fees average about 40% of a physicians usual and customary charge; and private health insurance payments to physician's are generally below national averages. A medical student who pays for his education with loans, as most do, has an average $50,000 indebtedness upon graduation. The pressure to practice in urban, more affluent areas in order to maximize earnings to pay back these loans is intense. These hard economic realities make it extremely difficult to attract physicians to rural areas of Mississippi.

THE ESCALATING COST OF HEALTH CARE

Although the charges of physicians and hospitals in Mississippi are among the lowest in the entire country, the costs of health care have continued to escalate at a faster pace than increases in incomes.

The increase in health care costs is driven by several factors, including new and expensive technology, aggregate population growth, more health-conscious consumers who utilize more services and technology, inflation, the practice of "defensive medicine" due to increased medical malpractice litigation, and the health problems associated with increasing societal problems such as AIDS, violence and drug abuse. Mississippi is not immune from any of these things and our generally low income level and lack of state financial resources make it even more difficult to absorb the economic impact of these and other factors influencing the cost of care.

The number of uninsured and the high percentage of the population covered by reduced payment programs like Medicare and Medicaid further exacerbate the overall costs problem in Mississippi, since those unrecoverable costs of providing care have to be passed on to persons covered by private health insurance. This only increases the cost of health insurance coverage and puts it further out of the reach of employers and employees.

THE SOLUTION

MSMA has identified four broad areas for major activities and reform of current practices that we believe will substantially address the majority of problems driving the issue of access to care. These four areas are:

Health Insurance Reform:

Employment-based group insurance is the most common source of health insurance coverage in America; yet, as noted earlier, fully 58% of the working age uninsured in Mississippi are employed. By in-

creasing the availability of health insurance coverage at the work place a major part of the uninsured problem could be addressed. However, before employers can be expected to provide health coverage, particularly the small employer with less than 25 employees, group insurance must be made more affordable and less price volatile. A number of health insurance reforms are proposed to accomplish this.

Medicaid Enhancement and Expansion:

Although Mississippi receives 80 cents out of every dollar it spends on the Medicaid program from the federal government, the state still spends only approximately $45 per person on health care compared to the national average of $65. By taking advantage of Medicaid expansions allowed by law, approximately 140,000 currently uninsured Mississippians would have access to needed health care through this program. And by implementing a statewide case manager program the Medicaid patient would have increased access to medical care throughout the state at an overall reduction in costs.

Increasing the Availability of Care in Rural Areas:

Increasing the type and number of physicians practicing in rural areas of Mississippi is a critical factor in extending health access. No single approach will adequately solve the problem of attracting and retaining physicians in rural areas, but a number of incentives can be implemented which will assist in accomplishing that goal.

Health Care Cost Containment:

That cost influences access to health care is undeniable. Increases in health care cost must be contained if health insurance is to be within reach of employers and employees, and if public programs like Medicare and Medicaid are to continue to be a realistic and affordable use of our tax dollars in taking care of the poor and elderly. It is incumbent upon both health care providers and patients to ensure that the system is used wisely, that only necessary care is provided at reasonable prices and that we all pursue healthy lifestyles that result in the preservation of our precious health resources.

Several recommendations falling into each of these four areas are being proposed by MSMA to address the problem of access to health care in Mississippi. Each of them is described in the material that follows.

RECOMMENDATIONS

I. HEALTH INSURANCE REFORM

- **Recommendation 1: For small employer groups of 25 or fewer employees,**

  - **Require community-based, rather than experience, rating of premiums.**
  - **Prohibit pre-existing condition limitations on coverage.**
  - **Require guaranteed renewability of coverage with limits on premium increases**
  - **Permit offering an "essential benefits" policy, such as the one developed by the American Medical Association, that is exempt from state mandated benefits requirements (see appendix A).**

Determining the cost of health insurance on the basis of "community rating" means that all persons in a given community would pay the same rate. Utilizing "experience rating" means that the premiums are determined on the basis of previous claims history and the risk associated with a particular group within that community. Requiring community rating accross all small groups would spread the risk among the entire group and permit higher risk groups to obtain insurance at lower rates. The utilization of "experience rating" and limiting coverage for pre-existing conditions allows insurance companies to deny and limit coverage for some employees and to engage in "low ball/ high ball" techniques that inevitably cause employers to forfeit coverage.

- **Recommendation 2: Allow health insurers to offer an "essential benefits" policy exempt from state mandated benefit laws to individuals, families or groups that have been without such coverage during the preceding 12 months.**

Mandated benefits are laws which require health insurance policies to cover certain individuals, conditions or providers. Mississippi has 12 such mandated benefits that are required by law, all of which drive up the costs of health insurance and put it beyond the reach of many families and small employers. By allowing insurers to write a policy covering only the essential hospital and medical benefits; exclusive of costly mandates, those individuals, familes, and small groups without insurance would have access to less

expensive coverage.

◆ **Recommendation 3: Grant a premium tax credit to insurance companies offering policies to small groups that comply with the policy provisions included in Recommendation 1.**

By offering a credit against the 3% premium tax imposed on insurers more compaines would consider offering coverage to small groups that was tailored to the small group market.

II. MEDICAID ENHANCEMENT AND EXPANSION

◆ **Recommendation 4: Consideration should be given to expanding Medicaid eligibility by taking advantage of one or more of the following coverage options.**

- **Initiate a "medically needy" program to cover individuals with catastrophic health needs.**
- **Raise the age threshold for persons eligible for Medicaid through the Aid to Families With Dependant Children (AFDC) program from 18 to 21 years of age.**
- **Base AFDC eligibility for Medicaid on a standard of need which is fixed at 50% of the federal poverty level.**

Exercising the first option would add about 55,000 persons to the Medicaid program. Option two would add around 20,000, while option three would add approximately 65,000 to the program. By instituting all three options for expanding eligibility for the Medicaid program as allowed by federal law a total of around 140,000 of the currently 475,000 uninsured Mississippians would have access to needed health care.

◆ **Recommendation 5: Require the Division of Medicaid to implement a statewide case management program for Medicaid recipients.**

Case management is one means of increasing Medicaid access to care while reducing costs. Under the typical Medicaid program like Mississippi's, the recipients essentially have a credit card and all they have to do is find someone who will honor it. Case management programs, which have been implemented in at least 16 states, link a Medicaid recipient with a primary care physician who increases access by providing continuous, rather then episodic, service. The case manager/physician also controls the flow of services from other providers, thus reducing costs in the process.

The Kentucky Medicaid program's "Patient Access and Care System" is the oldest and most successful case management program in the country. Since it was initiated in 1986, Kentucky officials estimate that it has saved the state approximately $20 - $25 million a year. The U.S. Health Care Financing Administration estimates that Medicaid case management programs save a state an average of $121 per year per recipient. Utilizing this figure, Mississippi could save approximately $24 million annually by implementing a case management program for the state's 200,000 AFDC recipients alone.

III. INCREASING THE AVAILABILITY OF CARE IN RURAL AREAS

◆ **Recommendation 6: Extend the current 10 percent bonus now given on Medicare payments to physicians who practice in Health Professions Shortage Areas (HPSAs) to payments under the state Medicaid program.**

In recognition of both the rigors and reduced earning capacity associated with rural medical practice and the need to attract physicians to undeserved areas, the federal Medicare health insurance program for the elderly awards a 10 percent reimbursement bonus to physicians who practice in HPSAs. If Mississippi were to extend this bonus to physician payments under the Medicaid program it would serve as an increased incentive to attract needed doctors to underserved areas of the state.

◆ **Recommendation 7: Extend sovereign immunity protection to private physicians who provide medical care under contract with the State Department of Health.**

The State Department of Health provides a number of health services to the poor and uninsured through its county health departments. These programs target chronically ill adults, children and pregnant women, and utilize the services of health department staff working with private physicians in the community who contract with the department. This program is

particularly crucial to the delivery of maternity services to the poor and uninsured, since almost half of the women in Mississippi who give birth in any given year receive their prenatal care in local county health departments. The ability to recruit volunteer private physicians in the community is crucial to the continuation and expansion of these vital services. That task could be made much easier if the state would ensure that those private physicians who contract to provide services to the poor and uninsured pursuant to a contract with the health department are granted some protection from liability through the state's sovereign immunity laws.

- **Recommendation 8: Modify the existing state medical loan and scholarship program to provide for additional incentives for practice in underserved areas, such as practice start-up grants, locum tenens assistance, and professional liability insurance subsidies for family practitioners providing obstetrical services.**

Currently, the state provides loans and scholarships for students attending medical school under which repayment of the principal and interest is forgiven in exchange for practicing in a community of less than 10,000 population for a specified number of years. Because of the availability of low interest government loans and other forms of student financial aid, the program is little used and has failed to provide adequate incentives to attract new medical graduates to underserved areas. The State of Tennessee has recently expanded its medical education loan program to provide for additional financial assistance programs as an incentive for rural practice. These include grants to assist in starting a medical practice, subsidies for family practitioners to pay for the additional cost of medical malpractice insurance associated with delivering babies, assistance in locating and paying for the services of a locum tenens physician to cover for the attending physician in his or her absence, and practice income subsidies for locating in an economically depressed area. Each of these programs is contingent upon the physician agreeing to practice in a Health Professions Shortage Area for a fixed number of years. Mississippi should set aside a certain portion of its unused medical education loan and scholarship funds each year in order to fund and operate a similar program aimed at assisting physicians in underserved areas of the state.

- **Recommendation 9: Urge the University of Mississippi Medical Center to utilize federal Area Health Education Center (AHEC) funds to establish medical education opportunities in rural areas.**

Medical students and residents who receive a portion of their training in rural communities are more likely to return to those areas upon completion of their training. AHEC funds are available for the purpose of establishing such off-site educational experiences in local communities under the aegis of a medical school. These educational experiences can include rural rotations of students and medical residents through local community health facilities. The University of Mississippi Medical Center has not utilized AHEC funds to expand its educational opportunities into rural areas and it would be advantageous for the state to extend the medical center's training programs outside the Jackson area and into rural areas of Mississippi.

IV. HEALTH CARE COST CONTAINMENT

- **Recommendation 10: Provide state funding for the Mississippi Foundation for Medical Care to conduct small area analysis of health service utilization in order to identify aberrant utilization patterns and design educational programs aimed at correcting those practices.**

With appropriate and necessary funding the Mississippi Foundation for Medical Care could conduct a study of health service utilization by disease designation in each community in the state in which an acute care general hospital is located. This research would help identify those communities with above average or inappropriate utilization patterns and also serve as the basis for the development of educational programs that would assist the local health care community in addressing excessive utilization patterns that increase the overall costs of health care.

- **Recommendation 11: Urge all hospital medical staffs to utilize and monitor compliance with professionally-developed and recognized medical practice parameters.**

Practice parameters, which identify the medical consensus on the most effective treatment strategies

for a given medical condition, are presently being developed by several national organizations. These parameters could improve quality of care and assure the appropriate utilization of health care services. By hopefully reducing or eliminating inappropriate services, the cost of care should be correspondingly reduced.

- **Recommendation 12: Support enactment of a federal law addressing essential reform of the medical liability system.**

In 1989 the cost of health care attributable to medical malpractice insurance premiums and the practice of so-called "defensive medicine" was a staggering $20.7 billion. Any strategy to reduce the costs of health care must address our current medical liability system if it is to be truly effective. Most of the states, including Mississippi, have attempted to stabilize the costs of liability insurance through civil justice reform, but this effort has been mostly uneven and unsuccessful due to the legal profession's control of legislative committees with jurisdiction over judicial reform and the actions of state supreme courts in interpreting the various state constitutions. Any substantial and uniform relief in liability reform will almost have to be accomplished by the federal government. We urge Congress and the Administration to enact legislation that will reduce the cost of medical liability insurance and assure that the major portion of the premiums paid for such insurance are used for the appropriate compensation of negligently injured patients and not swallowed up by the legal system.

- **Recommendation 13: All physicians in Mississippi should be encouraged to adhere to the "Recommendations for Medical Care Cost Awareness" developed by the Mississippi State Medical Association (see appendix B).**

By incorporating these recommendations and suggestions into his or her medical practice, every Mississippi physician could individually contribute to stabilizing the cost of health care.□

Appendix A:

AMA'S MINIMUM BENEFITS IN REQUIRED EMPLOYEE HEALTH INSURANCE

Benefits Covered

Medically necessary physician services (MD and DO) as determined by physicians; office visits limited to 20 per person per year; outpatient services; inpatient semiprivate room and board and ancillary (inpatient days limited to 45 days per person per year); skilled nursing facility (180 days per person per year); ambulance; [skilled nursing, home health care and ambulance services can be covered at very minimal premium and hold potential for costs savings]; dental (office or hospital limited to repair necessitated by injury to sound teeth or jaw); overall benefit limit per person - one million dollars lifetime, and ICU at three times semiprivate room rate.

Benefits Not Covered

Routine physicals, including routine screening tests and exams; detoxification; sterilization, artificial insemination and family planning; cosmetic surgery; obesity treatment and weight loss programs; custodial or domiciliary care; eye glasses, hearing aids, orthopedic shoes, orthopedic appliances; personal comfort items; hospice; outpatient prescription and nonprescription drugs; outpatient speech, occupational and physical therapy.

Physician Services

Inpatient and outpatient physician services including diagnostic and therapeutic services provided in an inpatient or outpatient setting including the physician's offices. Such services include: diagnostic imaging and laboratory services; pre-and post-natal care of mother and infant, including delivery; immunizations and well-child care in accordance with guidelines of the American Academy of Pediatrics.

Outpatient Services

Outpatient facility services include emergency; outpatient facility and diagnostic services such as x-rays, lab tests, etc.; use of operating room and supplies; use of emergency room and supplies for emergencies; dialysis care.

Inpatient Hospital Services

Inpatient hospital care includes facility charges for services including semiprivate room, board and nursing services; drugs, oxygen, blood, biologicals, sup-

plies appliances and equipment used in the facility; operating, delivery, and recovery room charges; all medically necessary special types of care including but not limited to intensive, coronary, special care, dialysis, rehabilitation unit charges; diagnostic services; care for pregnancy and complications; and medically necessary ancillary services.

Home Health Services

Medically necessary home health services prescribed by a physician including the services of physicians, home health aides, medical social workers and nurses under the supervision of physicians; and ancillary services, medical supplies and appliances; oxygen, blood, and biologicals; and rental of durable medical equipment.

Financial Components

Deductible

- Basic deductible: $350 per individual, $750 per family
- No deductible on pre-natal and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8 in accordance with guidelines of American Academy of Pediatrics.

Coinsurance

- Coinsurance: In general - 20%, except as otherwise provided.
- Graduated coinsurance: First $1,000 of services, after deductible, at 30% coinsurance, after that at 20%, except as otherwise provided.
- Inpatient room and board: 30% coinsurance
- Outpatient facility services: 30% coinsurance
- Emergency room coinsurance after the deductible: $25 per visit
- No coinsurance on prenatal and postnatal care of mother and infant, nor for well-child care and immunizations up to age 8 in accordance with guidelines of American Academy of Pediatrics.

Out-of-Pocket Limits

- $1500 per individual $3000 per family
- Deductible and coinsurance amounts, but not premium payments, go toward meeting out-of-pocket expenses.

Premium

- Employee share no more than 20%
- More extended inpatient benefits: As an additional optional benefit, employers should be required to offer, solely at the employee's expense, coverage for unlimited hospital days.

Appendix B:

RECOMMENDATIONS FOR MEDICAL CARE COST AWARENESS

MSMA encourages the incorporation of these recommendations into the physician's medical practice.

1. Physicians are encouraged to volunteer fee information and to discuss fees with patients in advance of services.
2. Mechanisms should be developed to foster the sharing of diagnostic findings in order to avoid duplication of expensive diagnostic tests and procedures.
3. Physicians should be knowledgeable about hospital costs, ancillary charges, and the reimbursement mechanisms for hospital services.
4. When admitting patients, physicians should have a coordinated plan of action to assure diagnostic workups without delay. Ancillary departments can be consulted to help coordinate the action plans.
5. Physicians should admit patients to hospitals only when necessary. Insurance coverage should not be a determining factor.
6. Physicians are discouraged from ordering routine admission batteries. Test should be ordered only when indicated.
7. Physicians should avoid "standing" pre-op laboratory and x-ray procedures. Tests should be ordered only when necessary.
8. Physicians should organize and plan diagnostic tests and procedures to avoid emergency or "stat" procedures which carry exorbitant add-on fees.
9. Physicians should order laboratory and radiology tests with deliberation. When necessary, they should obtain consultations with pathologists and radiologists. Studies should not be ordered at the request or whim of the patient unless medically indicated.
10. Physicians should avoid routine use of hospital-based ancillary services such as respiratory therapy, physiotherapy, etc.
11. Physicians should initially order a drug in limited quantities until efficacy of the drug is established.
12. Physicians should plan hospital discharges in advance to preclude unnecessary prolongation of hospital stay.
13. Physicians should make every effort to shorten a patient's hospital stay without sacrificing qual-

ity of medical care. When possible, extended care facilities should be utilized.

14. Physicians should discharge patients on the basis of optimum care with considerations of daily hospital discharge time.
15. Physicians should not prolong a patient's hospital stay purely for the patient's convenience. Physicians should not be coerced by the family to keep the patient hospitalized.
16. Physicians and hospital administration should cooperate to reduce hospital costs.
17. Physicians should discourage the use of emergency facilities for outpatient non-emergency care.
18. Physicians should utilize ambulatory surgery facilities to avoid unnecessary use of hospital beds.
19. Physicians should obtain diagnostic procedures on an outpatient basis when appropriate.
20. Physicians should utilize home health services when appropriate.
21. Physicians should restrain fee increases.
22. Physicians should encourage patients to consider authorizing a durable power of attorney for health care decisions or signing a living will to prevent the needless expense associated with the unwanted prolongation of life.

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

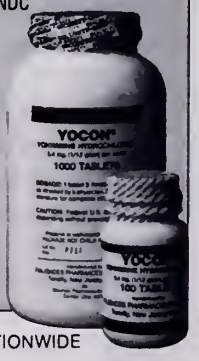
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.

219 County Road

Tenafly, New Jersey 07670

(201) 569-8502

1-800-237-9083



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720



The President's Page

JAMES C. WAITES, MD

THE "GOOD OLE DAYS"

It has occurred to me that most of my life I have heard people referring to the "Good Ole Days." First it was my grandparents, then my parents, and now myself. In thinking of these "Good Ole Days" I began to analyze what we were talking about. Basically it is a return to simpler times, to times that were not as hurried and confusing. In my grandparents case it probably meant a return to pre-depression days when life revolved around your family and your work. In my parents case it would mean a return to post World War II days. In my own case it would mean a return to the pre 1968 days, the times when third parties had very little influence on the practice of medicine. These were definitely the "Good Ole Days" for those of us practicing medicine.

However, we do have Medicare, Medicaid and DRG's. As these systems have developed it has become readily apparent that the status quo was not an option. Consequently, we are now in the age of RBRVS. By now you have been experiencing these for about three weeks. I, too, share in your frustrations of learning a new coding system, implementing a dual system and dealing with the endless mounds of paperwork.

All of these changes reminded me of a speech that I delivered several years ago to the graduating class at UMC. I used the illustration of Joseph, the Old Testament patriarch, who when sold into slavery by his brothers became a very important person in the Kingdom of Egypt and actually became part of the royal court. When his brothers came to Egypt several years later he was in charge. They were reconciled, as you recall, and he made the classic statement that "You meant it for bad, but God meant it for good." I am not suggesting that God in his infinite wisdom has had anything to do with the development of the RBRVS, but I am suggesting that like Joseph we can take advantage of our circumstances, exert our good qualities and become the leaders we should be. Joseph took advantage of his circumstances and turned bad to good. We must do the same. Our patients deserve our best

(Continued on page 21)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 1
JANUARY 1992

Resolve To Be Involved

Each time an event occurs that adversely impacts the practice of medicine I hear physicians asking, "how did this happen and why didn't someone do something about it?" Well, now is the time to start taking some action and become one of the "someones" that is trying to influence what is effecting medical practice today.

It is now time for new year's resolutions and a good one to add to your list is to become an active participant in your local and state medical organizations, hospital medical staff organizations, and other groups which are trying to control current events in medicine. Thirty years ago most practicing physicians were active participants in their local medical society. Today that level of participation has sharply dropped and this has adversely effected the capabilities of these societies.

Actions that strongly effect the practice of medicine today are not "just happening," they are generated by individuals and dedicated organizations with strong desires and goals that are contrary to those of organized medicine as a group. One of the best actions any practicing physician can take is to resolve to be involved. Such a resolution will require your willingness to make some sacrifices in both time and effort to actively participate in, generate, and direct the actions of "your" society. Also required is your willingness to resist the external forces that are not in the least concerned about your practice of medicine.

Over the past twenty years medicine has become fragmented by specialization, economic incentives, and individual goals which have strained or broken the common bonds binding organized medicine together. While it is perfectly natural for individuals and groups with more narrow or special interests to strongly pursue those particular practice objectives, there still exists a strong need for an actively supported group with an interest in what happens to medicine at large. This interest takes into account all the aspects of medical care from third party involvement, hospital practice, out patient medicine, home health, patient concerns and demands and multiple other problems facing us today. A fulfilled resolution such as this could have a strong effect on your future practice of medicine, no matter what area or specialty you are involved with and we would all benefit.

Happy New Year.

Myron W. Lockey, MD
Editor

Presidents's Page

(Continued from page 20)

in spite of the "bad" being thrown our way.

MSMA is doing its part by holding workshops to educate you, the physician, in the ways of RBRVS. The AMA continues to lobby Congress and exert every influence that it can in correct some of the obvious flaws in the system. But it comes down to each one of us as individuals to continue to make American Medicine the best in the world. Many things and circumstances have been hurled our way, but we can, by our attitude, "make it for good."

Happy New Year.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



"A Sign of the Times!"

HARRELD

CANTON

SALES – SERVICE – LEASING

HARRELD CHEVY-OLDS

Call Toll-free 1-800-451-3908



GIVE YOUR MEDICAL CAREER A LIFT.

The Air Force Reserve now offers an ***affiliation bonus of $10,,000.00 a year** to qualified general surgeons, orthopedic surgeons, anesthesiologists, and nurse anesthetists. Additionally, if you are an operating room nurse, you will qualify for **$6,000.00 a year.** Affiliation options range from one to three years. Place yourself a cut above the rest by calling the telephone number below or returning the attached coupon.

*This bonus is offered in the following states, Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Mississippi, North Carolina, Ohio, South Carolina, Tennessee, and Wisconsin.

Call: (404)421-4892

Or Fill Out Coupon and Mail Today!
To: SMSGT Hartung
14 AF/RSH
Dobbins AFB, GA 30069

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ____ No ____

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE

14-214-0028

A GREAT WAY TO SERVE

From the University of Mississippi Medical Center

Faculty Appointments At UMC

Five have been named in faculty appointments to the Schools of Medicine, Dentistry and Health Related Professions at the University of Mississippi Medical Center for the current academic session.

Dr. Norman C. Nelson, vice chancellor for health affairs, announced the appointments following approval by the Board of Trustees of State Institutions of Higher Learning.

School of Medicine appointments include Dr. Narra S. Reddy, assistant professor of neurology (research), Dr. Latha J. Brihmadesam, assistant professor of anesthesiology, and Dr. Jacquelyn L. Clark, instructor in family medicine.

Dr. Maylon J. Todd was named associate professor of endodontics in the dental school.

In the School of Health Related Professions, Melissa P. Daniel was appointed instructor in cytotechnology.

Dr. Reddy earned the BVSc (DVM) in 1974 and the MSc in 1976 at the A.P. Agricultural University of Hyderabad, India. He earned the PhD in 1981 at Kurukshetra University in India. He was assistant professor of microbiology at the Dairy Technology Institute of Osmania University in Hyderabad, India from 1980-1981, then took postdoctoral training at the Department of Animal Products Technology in Okayama University in Okayama-Shi, Japan from 1981-1983. He was appointed associate professor of dairy microbiology in the college of Dairy Science in Vidyalaya, Mohanpur, Nadia, India in 1984; then came to UMC in 1985 as a senior research associate in biochemistry. He had been research instructor in medicine (nephrology) at the University of Alabama at Birmingham since 1989.

Dr. Brihmadesam earned the MD in 1976 at the jawaharial Institute of Postgraduate Medical Education and Research, where she took her internship training. She took an internship at Bay State Medical Center in Springfield, Mass., and residencies there and at the University of Tennessee Center for Health Sciences. She was appointed instructor in anesthesiology at the Louisiana State University School of Medicine in 1982 and staff anesthesiologist at Charity Hospital of New Orleans. She was promoted to assistant professor of anesthesiology in 1985, then joined the UMC faculty as assistant professor of anesthesiology. She was appointed to the medical staff at the Department of Veterans Affairs Medical Center in Jackson in April, 1990, and has been chief of anesthesiology services there since July, 1990.

Dr. Clark earned the MD in 1987 at the University of Mississippi Medical Center and took her internship at Chicago Medical School and Lutheran General Hospital. She took her residency training at UMC.

Dr. Todd earned the DDS in 1968 at Creighton University and the MS in 1975 at George Washington University. He took endodontic residency training at Walter Reed Medical Center and Madigan Army Medical Center. He was chairman of the Department of Endontics and chief of endodontic services in the general dentistry residency program at Fort Hood, Texas from 1976-1981, and has held positions as chief of endodontic services at Fort Polk Dental Activity in Fort Polk, LA from 1981-1985; Hawaii Dental Activity at Shofield Barracks, Hawaii from 1985-1989; and at Fort Bliss Dental Activity in Fort Bliss, TX, since 1989.

Mrs. Daniel earned the BA in 1974 at Vanderbilt University, the certificate in cytotechnology in 1975 at UMC, and the MCS in 1991 at Mississippi College. She was assistant chief of cytotechnology at the University Hospital form 1975-1978, when she joined the Biomedical Labs cytotechnology staff in Birmingham, Al. She has been a cytotechnologist at UMC since September 1981. ❑

MSMA 124th Annual Session
April 29 - May 3, 1992
Ramada Renaissance Hotel
Jackson, Mississippi

Medical Organization

MSMA Auxiliary Holds Media/ Public Relations Workshop

On November 11, 1991, the Mississippi State Medical Association Auxiliary held a public relations workshop in Jackson. This workshop was developed for Auxiliary officers and committee chairman by MSMA Auxilary Public Relations Chairman Susan Donaldson of Tupelo.

Mrs. Darlene Young, AMA Southern Regional Vice-President was the featured instructor for the session. Mrs. Young gave examples of many excellent PR programs and projects currently being carried out by Medical Auxiliaries in the Southern Region. Mrs. Young discussed the basics of preparing and implementing a public relations plan and stressed the importance of auxilixary members getting involved for the long term. She also talked about establishing a time table and setting realistic goals for your public relations plan. Other speakers included Ginger Cocke, MSMA director of communications and Susan Donaldson MSMA Auxiliary public relations chairman. Susan, a former journalist, spoke about working with your local media representatives.

AIDS Helpline

for Health Professionals:
1-800-548-4659

Health care professionals with a question about HIV/AIDS now have a toll-free number to call: 1-800-548-4659.

Specialists at the Helpline can provide the following types of help:

- **Current HIV/AIDS information**
- **Customized literature searches**
- **Clinical consultations**
- **Educational information**
- **Surveillance data**
- **Journal article updates**
- **Specialized bibliographies**

The Aids Helpline, a free service of the **Delta Region AIDS Education and Training Center (ETC)**, is available to all health professionals in **Louisiana, Mississippi and Arkansas**, including nurses, physicians, dentists, social workers, psychologists, infection control specialists, and health administrators.



Among Workshop participants and speakers were, from left: Susan Donaldson, workshop chairman,wife of Dr. Tom Donaldson of Tupelo; Darlene Young, AMA Southern Regional Vice-President; Kathy Carmichael, MSMA Auxiliary President-Elect, wife of Dr. Ben Carmichael of Hattiesburg and Sylvia Walker, MSMA Auxiliary President wife of Dr. Billy Walker of Jackson.



ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

AXID®
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

1. Data on file, Lilly Research Laboratories. *See accompanying page for prescribing information.* © 1991, ELI LILLY AND COMPANY NZ-2947-B-249304

AXID®

nizatidine capsules



Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [10159t]

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

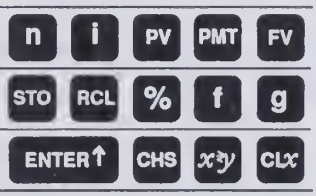
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- **No-Load Mutual Funds/Other Securities**
- **23 Years Experience**
- **Tested Asset Allocation Model**
- **Fee-Only Advisor**

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

Meetings

NATIONAL AND REGIONAL

American Medical Association, Annual Meeting, June 21-25, 1992 Chicago; Interim, December 6-9, Nashville, TN. James S. Todd, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

STATE AND LOCAL

Mississippi State Medical Association, 124th Annual Session, April 29-May 3, 1992, Jackson, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Mississippi Academy of Family Physicians, Annual Meeting, August 5-8, 1992, Gulf Shores, AL. Leontine Stevens, Executive Secretary, PO Box 1215 Ridgeland 39158.

Amite-Wilkerson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson, D.M. Segrest, MD, Secy., PO Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, MD, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hemando, Malcolm D. Baxter, Jr., MD, Secy., 124 W. Commerce St., Hemado 38632. County: DeSota.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: Ms. Jenkins, PO Box 4053, West Station, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, David G. Hall, MD, Secy., 150 Jeff Davis Blvd, Suite 130, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, P. Morris Parsons, MD, PO Box 590, Ackerman 39735. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Tuesday, March, June, September, November, December. Tom E. Stanford, Jr., MD, Secy., PO Box 7240, Tupelo 38802. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Joe T. Harris, MD, Secy., 2173 South Lamar Street, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, Thomas F. Adams, MD, Secy., 2104 5th Street North, Columbus, MS 39701. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Hal Moore, MD, Secy., 1214 Famsworth Avenue, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. A. J. Jackson, MD, 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Robert C. Clingan, MD, Secy., 1202 Mission Park Dr., Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials of the Accrediation Council for Continuing Medical Education (ACCME)" and the Council on Medical Education of the MSMA. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39202-1166

North Mississippi Medical Center
830 Gloster Street
Tupelo, MS 38801

Forrest General Hospital
Mamie Street and Highway 49 South
Hattiesburg, MS 39401

Mississippi Baptist Medical Center
1225 N. State Street
Jackson, MS 39202

Gulf Coast Community Hospital
180 DeBuys Rd.
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Seargeant Prentiss Drive
Natchez, MS 39120

King's Daugthers Hospital
Highway 51 North
Brookhaven, MS 39601

Charter Hospital of Jackson
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
150 Reynoir St.
Biloxi, MS 39533

Jeff Anderson Regional Medical Center
2124 14th St.
Meridian, MS 39301

Park View Regional Medical Center
100 McAuley Dr.
Vicksburg, MS 39180

Methodist Medical Center
1850 Chadwick Dr.
Jackson, MS 39204

Golden Triangle Regional Medical Center
2520 Fifth St., North
Columbus, MS 39701

Northwest Mississippi Regional Medical Center
Hospital Dr.
Clarksdale, MS 38614

Singing River Hospital
2809 Denny Ave.
Pascagoula, MS 39567

Greenwood Leflore Hospital
1401 River Rd.
Greenwood, MS 38930

Memorial Hospital at Gulfport
4500 13th St.
Gulfport, MS 39501

Baptist Memorial Hospital of North Mississippi
Highway 7, South
Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital
969 Lakeland Dr.
Jackson, MS 39216

Delta Regional Medical Center
1400 E. Union
Greenville, MS 39704

Methodist Hospital
5001 W. Hardy St.
Hattiesburg, MS 39401

MS State Department of Health
PO Box 1700
Jackson, MS 39215-1700

Personals

Paul M. Allen of Pascagoula gave a presentation entitled *Hysteroscopic Endometrial Abalation* at a conference on Modern Techniques and Treatments of Obstetrics and Gynecology in New Orleans.

William R. Arnett of Hattiesburg recently received board recertification in Family Medicine from the American Board of Family Practice.

Ronald A. Bullock of Hattiesburg recently received board recertification in Family Medicine from the American Board of Family Practice.

David H. Cheatham has associated with the Gulf Coast Pediatric Clinic at 450 East Pass Road, Gulfport.

C. Ralph Daniel, III, of Jackson recently gave talks in New York at a Columbia University sponsored symposium and in Dallas at the Annual American Academy of Dermatology meeting on nail disorders.

Charles W. Emerson, Jr of Jackson has relocated his office to the Arthritis Surgery Institute, 631 Lakeland East Drive, Building B.

R. J. Field, Jr of Centreville has been elected president of the Tulane Surgical Society for 1991-92.

Howard Freeman of Jackson is the medical director of Pathways, a partial hospital program for a new type of psychiatric services in Mississippi.

Fred H. Ingram of Jackson has been elected chairman of the Mississippi Section of The American College of Obstetricians and Gynecologists (ACOG).

Virginia Anne Jones of Jackson has associated with the Woman's Clinic, 953 North Street, Jackson, MS, for the practice of obstetrics and gynecology.

John William Lewis, Jr., of Rosedale has been recertified as a diplomate of the American Board of Family Practice.

William M. McKell, Jr., of Pascagoula recently spoke to the South Mississippi Records Association on colonoscopy. He has also been voted Medical Advisor of the Southeastern Outdoor Press Association.

Lynn McMahan of Hattiesburg recently lectured at the American Academy of Ophthalmology at a meeting in Anaheim, CA. He discussed how modern cataract surgery is possible for patients on blood thinners.

Physicians' Recognition Award

Two MSMA members were named recipients of the AMA Physicians' Recognition Award in November 1991. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These two individuals are presented below by medical society.

Central Medical Society

Rajinder K. Arora, MD

William Hollis Burrow, MD

Robert Ritter of Jackson spoke on Attention Deficit Disorder at the December meeting of the Mize PTA.

Bharat Sangani of Gulfport has been elected to fellowship in the American College of Cardiology, Bethesda, Maryland.

F. Clark Sauls has associated with the Hattiesburg Clinic in the practice of cardiovascular surgery with the South Mississippi Heart Institute.

Ralph Sneed of Jackson, an Otolaryngologist announces his retirement on January 1, 1992.

Wendy R. Tennyson of Brandon has associated with Methodist Medical Clinic, 116 East Main Street, Florence, MS in the practice of family medicine.

William P. Thompson of Yazoo City has been recertified as a diplomate of the American Board of Family Practice.

Plez Tinsley, Jr. of Jackson has been appointed to serve a three year term on the committee of Practice Management for the American Academy of Otolaryngology - Head and Neck Surgery.

Edward R. Turnbull of Laurel has been inducted into the American Orthopaedic Society of Sports Medicine (AOSSM).

Winfred Wiser, of Jackson received the Outstanding Program Director of the Year Award from District Seven of the American College of Obstetricians and Gynecologists (ACOG). The district represents 37 medical schools in the Southeast. The award is prized among ob-gyn faculty because the senior ob-gyn residents in the district select the recipent. Dr. Wisner is the only honoree to have received the award twice.

Willie Lee Wells of Bruce has been recertified as a diplomate of the American Board of Family Practice. ❑

Employers Insurance, Inc.

INTRODUCES:

A+ Rated Companies
Low Major Medical Insurance

• GROUPS • INDIVIDUALS
• INDIVIDUAL DRUG CARD
Saves Up To 60%
• DISABILITY INSURANCE
• LIFE INSURANCE

Call Us For A Quote, Today!
366-7293
1-800-844-0093

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (404)421-4892

Or Fill Out Coupon and Mail Today!
To: SMSGT Hartung
14 AF/RSH
Dobbins AFB, GA 30069

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE

A GREAT WAY TO SERVE

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings Up To 15 %
✔ 2. Established by Your Association	
✔ 3. Savings over what you currently are paying	
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association



"When I realized my chances of becoming disabled by age 65 were *three times greater* than the chances of death . . .

I compared disability insurance plans. And I decided that my MSMA-endorsed disability insurance plan

SERVES ME BEST!

It's not group insurance, but an individually-owned policy which is *non-cancellable* and *guaranteed renewable.*"

If you're a member of the Mississippi State Medical Association you may be eligible for this outstanding professional disability plan at *discounted premiums*.

- Non-cancellable, guaranteed renewable
- Medical specialty protection
- Presumptive loss provision
- Indexing of prior earnings
- Waiver of premium
- Cost of living rider
- Future disability insurance option
- Lifetime accident and sickness rider
- Total and residual disability protection

Offered by Paul Revere Insurance Company to MSMA members through its exclusive representatives, Professional Disability Specialists.

Jon B. Wimbish, Disability Specialist

1501 Lakeland Drive, Suite 200 Jackson, MS 39216 Telephone 362-9800

Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskett accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be my graphically boxed and printed as part of the published manuscript.

Key Words should follow the abstract and be identified as such. Provide three to five key words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination,

Treatment and Technique, Results, Discussion, and Summary.

References must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

Journals

[1] **Author(s).** Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] **Title of article.** Capitalize only the first letter of the first word. [3] **Name of Journal** followed by no punctuation, underscored, and abbreviated according to List of Journals Indexed in Index Medicus. [4] **Year of publication;** [5] **Volume number:** Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] **Inclusive page numbers.** Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol* 1979;71:680-692.

Books

[1] **Author(s).** Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] **Title,** Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less that four letters. [3] **Edition number,** [4] **Editor's name.** [5] **Place of publication,** [6] **Publisher,** [7] **Year,** [8] **Inclusive page numbers.** Do not omit digits.

Example: DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in Cardiovascular Medicine, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

Illustrations should be submitted in duplicate in an envelope (paper clips should not be used on illustrations since the indentation they make may show on reproduction). Legends should be typed, double-spaced on a separate sheet of paper. Photographic material should be high-contrast glossy prints. Patients must be unrecognizable in photographs unless specific written consent has been obtained, in which case a copy of the authorization should accompany the manuscript. All illustrations should be referred to in the body of the text. Omit illustrations which do not increase understanding of text. **Illustrations must be limited to a reasonable number** (four illustrations should be adequate for a manuscript of 4 to 5 typed pages.) The following information should be typed on a label and affixed to the back of each illustration: figure number, title of manuscript, name of senior author, and arrow indicating top.

Tables should be self-explanatory and should supplement, not duplicate, the text. Each should be typed on a separate sheet of paper, be numbered, and have a brief descriptive title.

Acknowledgements are the author's prerogative; however, acknowledgement of technicians and other remunerated personnel for carrying out routine operations or of resident physicians who merely care for patients as part of their hospital duties is discouraged. More acceptable acknowledgements include those of intellectual or professional participation. The recognition of assistance should be stated as simply as possible, without effusiveness or superlatives.

Galley Proofs will be mailed to the principal author for corrections. Reprint order forms will accompany galley proofs.

Placement Service
Physicians Wanted

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

Pascagoula Mississippi - Anesthesiologist Position Available for BC/BE Anesthesiologist. We administer all types of anesthesia including: open heart, cardiovascular, obstetrics, and general. Current compensation package competitive nationwide. Fringe Benefits include health, dental, life, long-term disablity, and malpractice insurance. Also included continuing education allowances, holidays and vacations. Local climate offers year-round recreation opportunities outdoors. Progressive city on Gulf, home to US Navy, many manufacturing facilities along with local seafood industries. Excellent school systems including division of University of Southern MS. Send CV to Pascagoula Anesthesia, Ltd. P.O. Box 1684, Pascagoula, MS 39568, (601)769-1021.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

Exceptional Internal Medicine Opportunity. Member of 10-physician IM Multispecialty group. 1 in 4 coverage. Enjoy a most desirable community as well as a very progressive medical clinic. Excellent compensations and benefits. Paid interviewing and relocation expenses. Send CV to Linda Crowson, Meridian Medical Associates, P.A., 2nd Floor, 2024 15th Street, Meridian, MS 39301.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Family Practice/ ER Physician needed for fill-in coverage for CME, vacation, and Saturdays, 9:00 am to 6:00 pm. North East Jackson. Call 957-2273.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

MEA

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Classified

For Sale or Lease - Attractive office building in Jackson, on Highway 18 near Methodist Medical Center (formerly Hinds General Hospital). **8,000 sq. ft. available in suites and individual offices; newly carpeted and painted.** Ideal for Doctors or Medical Clinic. **Call 366-2478 or 354-3000.**

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

For Sale By Owner: EYE, EAR, NOSE and THROAT CLINIC equipped and in use at present. Located: Biloxi, MS, owner plans on retiring within next two years. 1-601-374-3644.

COLOSCOPE AND PLETHYSMOGRAPH FOR SALE. Excellent Condition. Call Collect 601-769-6389.

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

For Sale or Lease - Attractive office building 4200 sq. ft., 955 North State Street, Jackson, MS. One Block from Baptist Medical Center. Call (601) 948-1707.

Items for the
Placement Service
should be sent to the Editors,
***Journal MSMA*, PO Box 5229,**
Jackson, MS 39296-5229.

The advertising rate is $2.00 per line or $75.00 per 1/4 page block. Rate cards available upon request.

Index to Advertisers

CancerPay Plus 10

Disability Determination 37
Doctors Insurance Reciprocal 28

Eli Lilly & Co. ..... 26 & 27
Employers Insurance, Inc. 31
Employer Plus, Inc. 7

Harreld Chevrolet-Oldsmobile 22

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 27
MS Emergency Association 36
MS Methodist Rehabilitation Center ..... **second cover**
MS Physicians Insurance Company 32
MS State Department of Health 8
MSMA Benefit Plan & Trust 4

MSMA Sponsored Insurance Plan 9

Palisades Pharmaceutical 18
Premier Printing 18

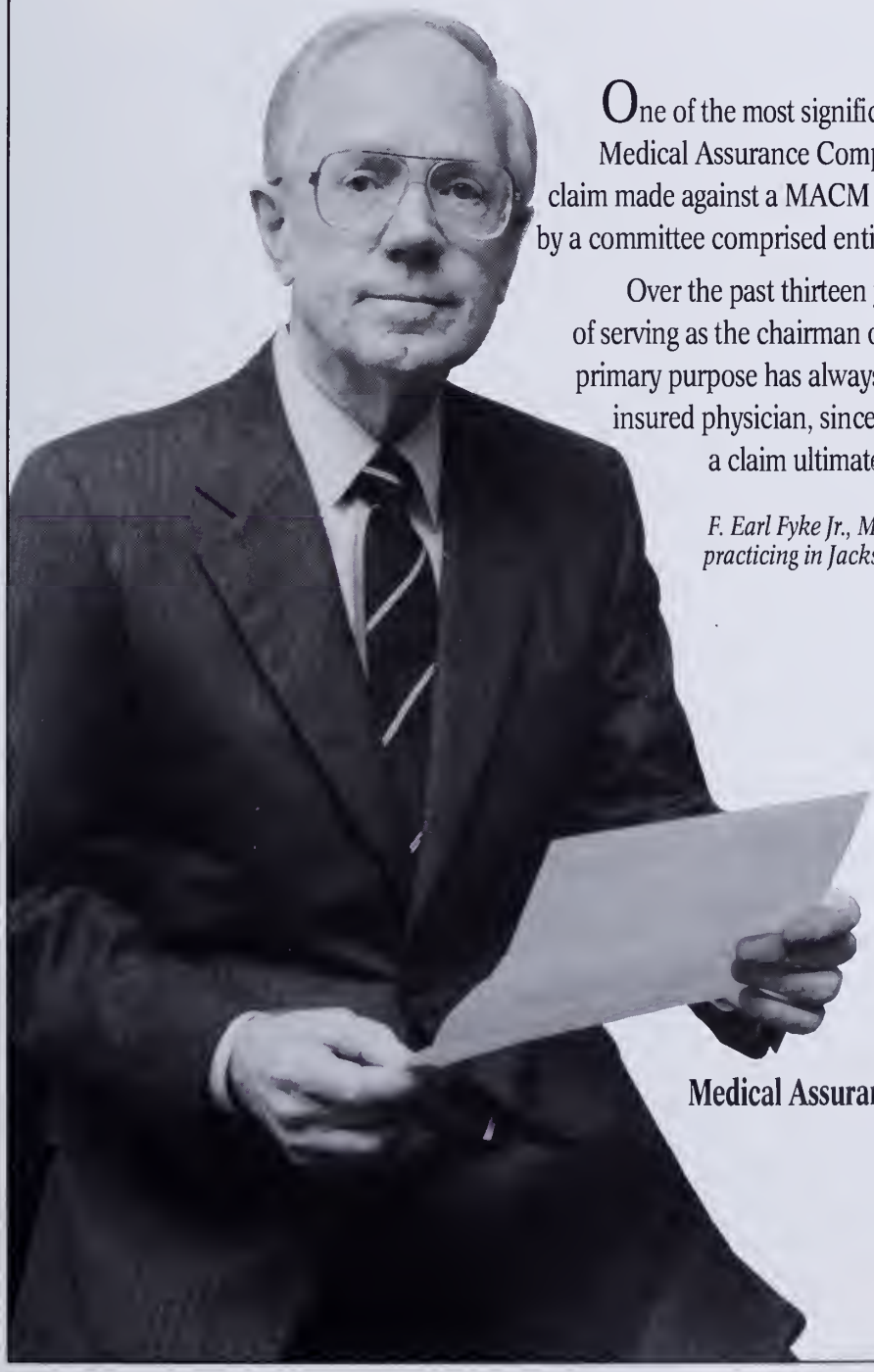
Searle ..... **fourth cover**
Systems Corporation 4

The Doctors' Company 19
Trustmark 3

US Air Force 8
US Air Force Reserve 23
US Air Force Reserve 31
US Army Reserve 6

Jon Wimbish 33

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

LIBRARY

JAN 2 8 1992

N.Y. Academy of Medicine

ONCE DAILY 180mg Calan® SR (verapamil HCl 180 mg)
SUSTAINED-RELEASE CAPLETS

The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE G.D. Searle & Co.
Box 5110, Chicago, IL 60680

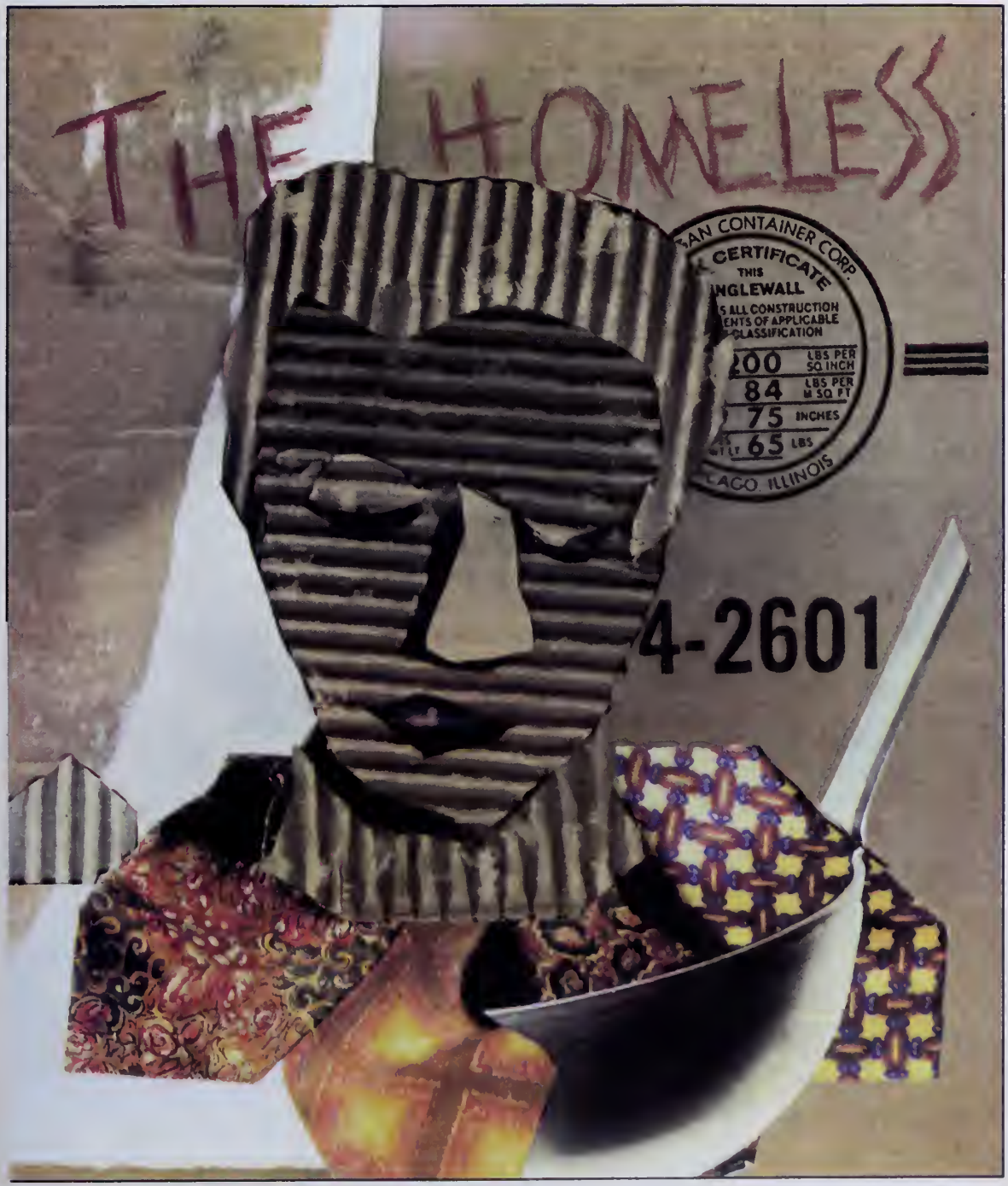
A91CA6148T



JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

FEBRUARY 1992



N.Y. ACADEMY OF MED
2E F 103RD ST NY 10029-5207
NEW YORK



You mean this is what I've been training for all my life?



He trains year-round on the weights and on the track. But it wasn't long ago when he thought the race was over.

A diving injury had left Sammy Shute a quadriplegic. That's tragic news for anyone, but especially someone like Sammy who's been an athlete all his life.

With a whole new set of issues to come to grips with in his life, Sammy found the strength he needed in the therapy at MMRC.

"I looked at therapy as competition," he said. "To do something better than I'd done it before. I guess you could say I was in competition with myself."

Over time, the staff helped him realize that by giving 110 percent every day, there was a multitude of things a person could do in a wheelchair. Like racing, for example. He went on to become an inspiration not only to others, but to the very people who'd been such an inspiration to him.

It's that one-on-one relationship between patients and staff that makes MMRC the South's leading rehabilitation center. If you don't believe it, come out to the races one day. You'll see the proud results from start to finish.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

FEBRUARY 1992 VOLUME XXXIII NUMBER 2

SCIENTIFIC ARTICLES

Homelessness and Chronic Mental Illness in Mississippi 39
Anwant Chawla, MD and James L. Griffith, MD

Diagnosis and Management of Sinusitis in Children 45
Mickey P. Wallace, MD

SPECIAL ARTICLE

AMA Addresses Medicare Reform Issues 50

EDITORIALS

Wild Dogs and Wildebeest 52
James C. Waites, MD

The Eagle Flies on the First 53
Joseph E. Johnston, MD

DEPARTMENTS

Letters 54
Current Opinions 57
Medical Organization 62
New Members 71
Deaths 72
Personals 74
Placement Service 77

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD,
Chairman
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
James C. Waites, MD
President
William C. Gates, MD
President-Elect
Don Q. Mitchell, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 2

February 1992

Dear Doctor:

The MSMA 124th Annual Session will be held April 29 - May 3, at the Ramada Renaissance Hotel, Jackson. Physicians who would like to reserve **Scientific Exhibit space** should write: Scientific Exhibits, MSMA, PO Box 5229, Jackson, 39296-5229. The letter requesting space should include: **(1) the title of the exhibit; (2) the authors of the exhibit: (3) an estimate of the amount of exhibit space needed; and (4) a brief synopsis of the subject to be exhibited.**

The American Orthopaedic Foot and Ankle Society (AOFAS) will hold a course on *Practical Foot & Ankle Care for Primary Care Physicians* April 3 and 4, 1992, at the Mobile Hilton, Mobile, Alabama. The American Orthopaedic Foot and Ankle Society designates this continuing medical education activity for 10 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. The program has been reviewed and is acceptable for 9.50 prescribed hours by the American Academy of Family Physicians. For further information contact: The American Orthopaedic Foot and Ankle Society, 1-800-235-4855.

The National Rural Health Association will hold its 15th annual national conference on rural health, *Rural Health: Caring for the Country*, May 6-9, 1992, at the Hyatt Regency Crystal City Hotel in Washington, DC. The conference is designed to :

- develop practical skills and techniques in health services administration, organization and research;
- present practical clinical sessions of interest to rural health providers;
- showcase current policy issues affecting rural health services; and
- report the results of research applicable to rural health service administrators and providers.

For further information contact The National Rural Health Association, (202) 232-3553.

The Juvenile Diabetes Foundation International announces the availability of grants in diabetes research for the funding year September 1, 1992 to August 31, 1993. Applications may be obtained from: Grant Administrator, Juvenile Diabetes Foundation International, 432 Park Avenue South, New York, NY 10016, 212-889-7575. Each Grant application is subject to scientific peer review by the Medical Science Advisory Board and approval by the International Board of Directors. These bodies evaluate the scientific merit of the application; the qualifications, experience and productivity of the investigator; the facilities available; and the relationship of the research to the cause, cure, treatment and/or prevention of diabetes mellitus and its complications.

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings Up To 15 %
✔ 2. Established by Your Association	
✔ 3. Savings over what you currently are paying	
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 2

MEDICAID PRESENTS A MAJOR CHALLENGE

Tupelo, MS -- Mississippi lawmakers, newly sworn into office, begin their four-year term with a long list of huge problems. All of them are related, in one way or another, to a lack of money. None of the problems will cause more political and moral consternation that funding for the Medicaid program. Medicaid is the nationwide state/federal partnership that provides health care for poor and disabled people. Its impact is particularly important in health care for the elderly in nursing homes, children and poor mothers with babies.

Legislators and Governor Kirk Fordice must wrestle with new confusing rules that probably will slash the amount of federal money coming into the state. The Legislature and Governor must decide if the state tax base for Medicaid is to be expanded and, if so, by how much.

Medicaid funding is a federal-to-state match based on per capita personal income. Mississippi, the poorest state, gets the highest federal-to-state match: $4 for every $1 in state funds. The total Medicaid budget in Mississippi is about $1 billion -- a major economic factor any way it's examined.

Mississippi has relied since the late 1980s on a beneficial financing plan that brought more federal money into the state's Medicaid program. Hospitals have been able to donate a voluntary tax of up to $40 million to the state program. The state then used every dollar of the donations to generate a $4 to $1 federal matching grant. It also used a tax on hospitals, pharmacies, nursing homes and doctors providing Medicaid care that generated $25 million. This was used to obtain still more federal matching money.

That plan has been changed by Congress. The administration wanted to abolish it, but congressmen, including Mississippi's delegation, fought its abolition and hammered out a compromise law. The degree to which the matching formula has been changed is not clear. It is probable that the change will hurt the funding formula on Mississippi's end -- unless the Legislature commits general fund taxes or taxes on all health care providers to make up for lost revenue.

STATE URGED TO GUARANTEE HEALTH CARE

Jackson, MS - All Mississippians should have access to quality, affordable medical service, a task force for Governor Kirk Fordice concludes.

"If a person is not well-educated and not healthy, he faces very strong barriers to being a productive member of society," said John Hicks, president of the North Mississippi Medical Center in Tupelo who chaired the Governor's health-care task force. "Providing quality care will take financial commitment to the state Department of Health and to Medicaid," Hicks said.

Formed November 26, to advise Governor Fordice on policies, the task forces studied agriculture, community development and tourism, criminal justice, education, election reform, environment, government accountability and reform, health and human service, and health care.

Some recommendations won't be priorities on Fordice's Legislative agenda, said Joe Loyacono said. Many task forces suggested the state spend additional money to attack problems or set up programs. Governor Fordice has said that the state can't afford to spend more and must cut instead.



"When I realized my chances of becoming disabled by age 65 were *three times greater* than the chances of death . . .

I compared disability insurance plans. And I decided that my MSMA-endorsed disability insurance plan

SERVES ME BEST!

It's not group insurance, but an individually-owned policy which is *non-cancellable* and *guaranteed renewable.*"

If you're a member of the Mississippi State Medical Association you may be eligible for this outstanding professional disability plan at *discounted premiums*.

- Non-cancellable, guaranteed renewable
- Medical specialty protection
- Presumptive loss provision
- Indexing of prior earnings
- Waiver of premium
- Cost of living rider
- Future disability insurance option
- Lifetime accident and sickness rider
- Total and residual disability protection

Offered by Paul Revere Insurance Company to MSMA members through its exclusive representatives, Professional Disability Specialists.

Jon B. Wimbish, Disability Specialist

1501 Lakeland Drive, Suite 200 Jackson, MS 39216 Telephone 362-9800

Homelessness and Chronic Mental Illness in Mississippi

ANWANT CHAWLA, MD
JAMES L. GRIFFITH, MD

Chronic psychiatric disorders are known to occur with a high prevalence among a growing homeless population in American.[1] We sought through an ethnographic study to gain a better understanding of chronic mental illness as it exists among homeless persons in the Jackson metropolitan area and a better understanding of how to work therapeutically with this patient population. We interviewed homeless clients over a twelve week period at a Jackson homeless shelter one evening weekly. Additional interviews were conducted with staff and clients at other homeless shelters in Jackson and with public and private social agencies working with the homeless. We will briefly describe the problem of homelessness in Mississippi and its impact upon the chronically mentally ill. We will then offer some recommendations for working with homeless patients, based upon our experience.

HOMELESSNESS AS A NEW SOCIAL PROBLEM IN AMERICA

While there have always been some homeless people in American such as the legendary hobo, it has only been in recent years that large numbers of homeless have been primarily mentally ill. Deinstitutionalization of chronically mentally ill patients from large public psychiatric hospitals occurred in the 1950's and 1960's.[2] In Mississippi, for example, the census at Mississippi State Hospital fell from over 4,500 three decades ago to 2,000 currently.[3] A failure of state and federal governments to fund realistic community programs for care of the new outpatients led to substantial numbers of the chronically mentally ill living on the streets, lacking both financial resources and life skills needed to adequately care for themselves.[2,4,5] A 1985 study in Ohio followed 132 patients hospitalized with chronic schizophrenia, mood disorders, and other psychoses after their discharge into the community. Six months later, 47 were homeless.[6]

During the 1980's others were added to the original group of deinstitutionalized patients, due either to chronic drug abuse and or to national economic policies that dramatically reduced funding for public housing. For example, New York City had 170,000 single room living spaces in 1971, but only 14,000 in 1984, a span of time during which housing costs rose astronomically.[1]

Nationally, 26% of all homeless are estimated to suffer from mental illness, with one in four females and one in five males suffering from schizophrenia, an affective disorder, or a personality disorder.[1] However, an estimated 70% to 80% of homeless also abuse alcohol and/or drugs. Dual diagnoses of severe mental illness and substance abuse occur commonly.[1,7,8]

THE MISSISSIPPI EXPERIENCE WITH HOMELESSNESS

Homelessness, often the focus of national news, has received much less attention as a local problem within Mississippi. Information from the 1985 census suggested 300 to 500 homeless in Jackson based upon number of clients in homeless shelters, presumably a

low estimate since non-users of the shelters were not counted. The number of "hidden homeless" in Jackson -- those who do not frequent the homeless shelters due to fear of harm from other clients, whether paranoid or realistic, and those who live in abandoned buildings or move from friend to friend -- is entirely unknown.

In Jackson most services available to the homeless are centered in a loosely connected system of homeless shelters. A shelter typically consists of an old building in which cots can be placed in larger rooms to create a dormitory-style living arrangement with access to bathing facilities and some meals. Most of the shelters are located in the downtown and West Capitol Street areas of Jackson, including Community Stewpot, the Salvation Army, Gateway Rescue Mission, Helping Hands, the Sims House for Battered Women, and New Hope.

Most of the shelters see their mission as one of crisis intervention in which shelter and food and sometimes other assistance, such as clothing and bus fares, are provided on a temporary basis. Shelters are open on a first come, first serve basis from early evening until morning, providing a clean bed, a shower, an evening meal, and breakfast. An excess of homeless clients usually means turning away latecomers. Some are afraid to stay in the shelter due to fears of assault during the night.

The different shelters are mostly operated by religious groups that seek somewhat different ends, depending upon the extent to which evangelizing the faith is also a goal in addition to ministering to physical needs of the poor. Community Stewpot is an interfaith organization with broad support among churches and synagogues in Jackson. It offers food, shelter, and other assistance to the poor through a program similar to those developed through the Catholic Worker movement in New York City over the past fifty years. Community Stewpot includes within its organization the Harbor House, an alcohol treatment program for low-income clients. The Gateway Mission is a fundamentalist protestant organization that seeks the spiritual conversion of non-Christian homeless. It offers food and shelter both as a physical ministry and as a way to create openings for dialogue about spiritual matters. The Sims House for Battered Women is operated by Catholic Charities as a part of a broad umbrella of Catholic social services to the poor. The Voice of Calvary organization provides medical treatment through an outpatient medical clinic.

However, problems related to physical existence are so overwhelming, and there have been no efforts within the shelter system to address psychiatric needs of the mentally ill. The chronically mentally ill are often stigmatized by non-mentally ill homeless. During our shelter visits, it was striking how clients organized their seating at their evening meal. The obviously chronically impoverished, disheveled, often psychotic clients gathered at the south end, with the more neatly dressed, temporarily homeless at the north and others in the middle.

Mississippi State Hospital, although mandated to provide only inpatient psychiatric treatment, has this year undertaken a trial project to provide intensive case management to their discharged patients who now live in the shelters. Services can be provided to as many as 30 patients a year through assistance in finding housing, such as a personal care home, and through organizing outpatient psychiatric and medical treatment for the patients.

WORKING WITH THE CHRONICALLY HOMELESS

We drew some tentative conclusions from our three month experience in counseling homeless shelter clients:

a. We found it important to recognize that the homeless are a diverse group. Compared to simplistic distinctions drawn on television about the homeless and their problems, our conversations with specific homeless clients revealed a multiplicity of life stories that only shared the common ending of winding up in the shelter with no other place to live. One chronically psychotic client has lived in and out of shelters since discharged from Mississippi State Hospital years ago. He said he could not get transportation back and forth to outpatient treatment at Jackson Mental Health Center. Another lived intermittently at the shelters when on drinking binges and home with his wife otherwise, while another, a truck driver, awaited reinstatement of the driving license he lost to unpaid traffic tickets. This diversity requires that each person's problem be investigated and understood as a special case.

b. We found that we must accept the existence of a high level of mutual disgust and mistrust among the chronically homeless, often expressed towards helping professionals as well. The homeless clients themselves emphasized their differences from one another. None we interviewed wished to own the label of "homeless," which was seen as shameful.

Efforts to conduct group therapy aimed at teaching job interviewing and problem-solving skills failed, as

it was discovered that shelter clients typically viewed one another as potential threats, not as potential friends and supports. As we learned, life on the streets is treacherous. Social security and welfare checks are stolen. Assaults and rapes occur regularly, particularly when the victim is too intoxicated to defend himself or herself. Homeless clients typically see no reason to trust or seek relationship with other homeless clients in the shelter, save for a single personal friendship that may have arisen along the way. There is little group comradery.

This habitual distrust seems to carry over to professionals as well. Many homeless feel betrayed by American institutions and the hopeful visions they embody:

An elderly man with whom we had conversed amicably the week before came to tell us how pleased he was because he finally was receiving his social security check. He came up in a friendly, engaging manner to say that he had in fact thought of something that we could be helpful with. He then asked for a new set of teeth. He knew that I was on the medical school faculty and thought that I could perhaps pull some strings to get him some free new teeth. When I said that I was unable to do this but told him how he could contact the dental school, he said, "You are just like the rest of them at the VA Hospital. You can go here, you can go there." He walked away saying over his shoulder, "This is America."

Most of those who sought and utilized our assistance had been homeless for only a short time, or had good reason to expect that they would find employment soon and would move to an apartment. For these the stay in the shelter was a temporary slip up rather than a way of life. Those who had been chronically homeless largely ignored our presence.

c. Problems with alcohol and substance abuse are pervasive and undermine otherwise well-designed efforts to offer assistance. Before resolution of other kinds of problems can begin for many of the homeless, treatment of alcohol and drug abuse must occur. "State dependent learning" was often a practical problem during our interviews. A problem might be discussed seriously when intoxicated in the evening hours, but little recall would carry over into the sober state the next day. Commitments to take therapeutic steps were forgotten. Time of day made a difference; interviews early in the day were more typically conducted in a sober state.

Providing needed alcohol and drug treatment programs will entail expanding publically funded treatment programs. Current public programs, such as the chemical dependency unit at Mississippi State Hospital, are already overextended with lengthy waiting lists for treatment. Homeless patients do not carry private health insurance required by most treatment programs in Mississippi.

d. A clinician can quickly become cynical and resentful due to the lack of immediate fruits for one's labor. The belief that the chronically homeless "want to live that way" may contribute little to effective care, but is a tempting conclusion for a clinician who repeatedly sees well-meant efforts to offer psychiatric and medical treatments fall apart. It appears that one must work from a larger perspective that does not depend upon the immediate gratification of seeing rapid behavioral change in most homeless clients. Many of the staff working in homeless shelters, both professional and volunteer, do so in the spirit of Jesus's words in the Book of St. John to "Feed my sheep."

Community Stewpot, for example, states in its brochure that, " . . . all persons are created in the image of God and that by ministering to those of the least of God's children, we are ministering to Him." This stance of spiritual service does not depend upon witnessing a desired outcome in order to continue the service. Some overarching commitment of a spiritual nature seems essential in order to prevent the growth of demoralization and cynicism among caregivers and clinicians.

e. Public health measures, including psychiatric treatment, may need to be set up insofar as possible along a "one shot intervention" model, since patient follow-up and continuity of care is likely to be nearly nonexistent. Seldom were shelter clients able to carry through with plans to meet weekly to work upon some life problems over time. As one client in his twenties said, "I live one second to the next second. By the time we finish talking, I don't know if I will be alive." The privilege of thoughtful diagnosis of a problem, carefully planned intervention, then follow-up to evaluate outcome is simply not possible with persons for whom only the immediate moment holds matters of concern. We came to believe it to be more prudent to complete some effective action, however small in scope, in one sitting, such as gaining admission to a detoxification program, administering medication, or assisting to obtain a bus ticket back home.

f. The unit of intervention needs to be larger than the individual homeless person. Homelessness as an event catches the eye of middle-class citizens for whom shelter is assumed to be an inalienable right.

However, this homeless status often exists as it is supported by broader behavioral patterns involving other persons and institutions, such as spouse abuse, patterns of drug use, and breakdown of outpatient treatment programs for the deinstitutionalized mentally ill.[5] It appears that the unit of treatment should involve in a coordinated manner the homeless person together with his or her social network of friends, family, and already involved social agencies and helping professionals.

CONCLUSION

The mental and physical health problems associated with homelessness can seem insurmountable. Within the complexity of economic and political factors interacting with medical and psychiatric illnesses, it is not always clear what kind of action as physicians would be effective if we are willing to act. Yet medicine, in the name of ethics or religion or a common humanity, has throughout its history labored with endurance against problems it did not have at the time the knowledge or resources to solve. One need only recollect stories of physicians at the bedsides of the dying during the great yellow fever epidemics in the early years of our state, or during the more recent plague of AIDS. Short of a definitive answer, there are contributions of value that physicians can make:

a. Despite recent downturns in physician incomes, physicians in a poor state such as Mississippi remain wealthy compared to average citizens of the state. Monetary contributions to an organization such as Community Stewpot or Voice of Calvary in Jackson, with their low operating expenses, volunteer workers, and well-designed ministries, make immediate impacts in the lives of those in need.

b. Medical screening clinics and free health clinics, provided by Community Stewpot and Voice of Calvary, need volunteer professionals who can commit small amounts of time on a regular basis to staff their clinics.

c. Mississippi was recently ranked 47th out of the 50 states in quality of public psychiatric services.[9] More than non-professional citizens, physicians carry greater political influence of the kind that can affect public policy. There is a great need for effective lobbying to provide community services for the chronically mentally ill and to hold accountable those entrusted with administration of public funds for the mentally ill. ❑

2500 North State Street
Jackson, Mississippi (39216-4505)

References

1. Grinspoon L (ed). Mental illness and homelessness: Part I. *The Harvard Mental Health Letter*. 1990;7:1-4.
2. Lamb HR. Deinstitutionalization at the crossroads. *Hosp. Community Psychiatry*. 1988;39:941-945.
3. Medical Records Department, Mississippi State Hospital, Whitfield, Mississippi, 1991.
4. Lamb HR (ed). *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association*. Washington, DC: American Psychiatric Assocation Press, 1984.
5. Lamb HR, Lamb DM. Factors contributing to homelessness among the chronically and severely mentally ill. *Hosp. Community Psychiatry*. 1990;41:301-304.
6. Belcher JR. Defining the service needs of homeless mentally ill persons. *Hosp. Community Psychiatry*. 1988;39:1203-1205.
7. *Homelessness in American: A Summary*. Washington, DC: National Coalition for the Homeless, 1991.
8. Breakey WR, Fischer PJ, Kramer M, Nestdt G, Romanoski AJ, Ross A, Royall RM, Stine OC. Health and mental health problems of homeless men and women in Baltimore. *JAMA*. 1989;262:1352-1357.
9. Torrey EF, Wolfe S, Flynn LM. Care of the seriously mentally ill: A rating of state programs. *Hosp. Community Psychiatry*. 1990;41:1272-1274.

Dr. Chawla is assistant professor of psychiatry and Dr. Griffith is associate professor of psychiatry in the Department of Psychiatry and Human Behavior, University of Mississippi School of Medicine.

THE UNITED STATES ARMY RESERVE

HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

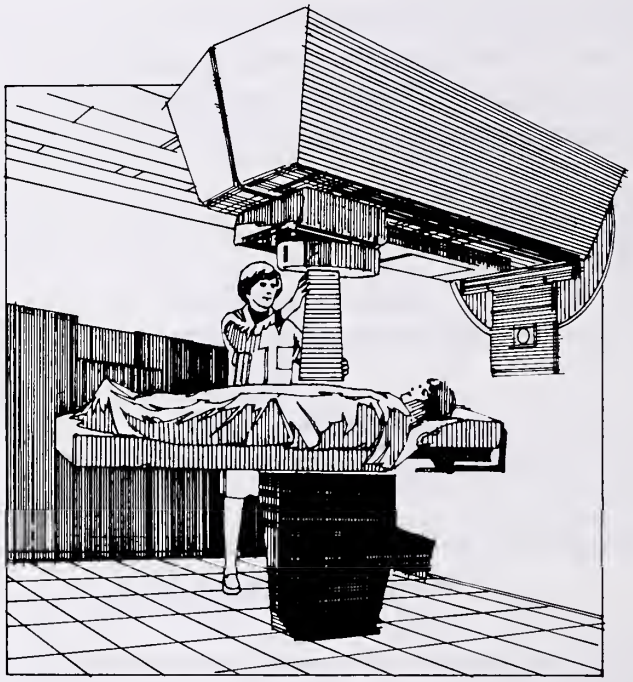
TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Diagnosis and Management of Sinusitis in Children

MICKEY P. WALLACE, MD

Sinusitis in children has been a more prevalent and recognizable disease in the past decade. This seems to be a result of increased physician visits, more availability of medical care, increased knowledge by physicians concerning this disease and improved imaging of the paranasal sinuses utilizing computer tomography. Children with sinusitis present with a variety of signs and symptoms and clinicians need to be aware of these in order to diagnose this sometimes "silent" disease. Sinusitis is more prevalent in asthmatic and allergic children.

With the advent of CT and MRI, developmental anatomy of the sinuses has become more clearly understood. At birth the ethmoid and maxillary sinuses are present and reach full development in early adolescence.[1] These sinuses drain into the middle meatus of the nasal cavity, creating what is referred to as the ostiomeatal complex. Obstruction of this area leads to sinusitis and polyp formation. Sphenoid sinus development begins at about the age of two years, while frontal sinus development begins at about age six years. The sphenoid and frontals are not frequently infected in children, but become clinically important after the age of eight to ten years.[1]

SYMPTOMATOLOGY

Symptomatology in sinusitis in the child is somewhat variable, as listed in Table I. Any combination of these symptoms should lead the clinician to investigate the possibility of sinus disease. Children under the age of five are much less specific about their complaints. Fever, only occasionally noted, tends to be low grade, intermittent and rarely of a malignant nature. The most common symptoms are nasal obstruction and discharge, which may be anterior or posterior, and clear or purulent in nature. Posterior drainage frequently causes coughing, constant clearing of the throat, and what parents refer to as "snorting". The cough seems worse at night, when the child is in the supine position. Laryngeal irritation may produce hoarseness. Aspiration of this material frequently causes bronchitis and occasionally pneumonia. Headache is an infrequent complaint in children less than five years old.[1] When present it is usually frontal in location, and seems to be more severe and frequent during the morning hours. Younger children are also more likely to have increased irritability and poor appetite, secondary to the foul tasting purulent postnasal discharge. Nasal obstruction is not a frequent complaint by the child and is usually noted by the parent or physician, and results in chronic mouth-breathing, nasal stridor, snoring and loud breathing at night. Children with sinusitis may present with chronic sore throat.

Table I - SIGNS AND SYMPTOMS OF SINUSITIS

Anterior nasal discharge, clear or purulent
Posterior nasal discharge, clear or purulent
Daytime cough, frequently worse at night
Irritability
Nasal obstruction
Fever (low grade or intermittent)
Loss of smell
Halitosis
Chronic mouth breathing
Frequent bronchitis
Sore throat (frequently worse in the morning)
Frontal headache

SIGNS OF ACUTE AND CHRONIC SINUSITIS

Physical findings are variable and occasionally inconsistent, however, certain signs should lead the physician to consider sinusitis. A thorough nasal exam is essential and usually shows a boggy, erythematous mucosa and turbinate hypertrophy. The enlarged turbinates make examination of the posterior nose difficult but anterior rhinoscopy can usually be accom-

plished with the otoscope. Topical nasal constrictors are usually necessary for completing the essential examination of the middle turbinate, middle meatus and the lateral nasal wall. Large turbinates and middle meatus purulence are a sine qua non of sinusitis. In absence of purulence one frequently sees dried crusting on the turbinate or lateral nasal wall. In severe cases one may see medial bulging of the lateral nasal wall with obliteration of the middle meatus. Polypoid granulomatous material may fill this area. There are clear and obvious signs of chronic sinusitis (see Figures 1, 2 and 3).

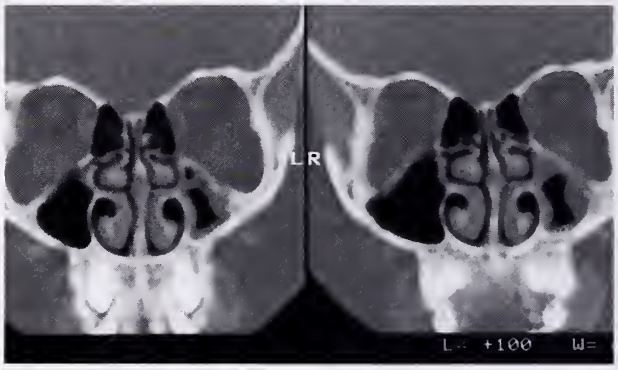


Figure 1 - Blocked ostiomeatal complex of the right maxillary sinus, clear ethmoid cavities bilaterally and a blocked ostiomeatal complex on the left with associated more progressive mucosal thickening throughout the entire maxillary antrum. Turbinates are moderately enlarged.

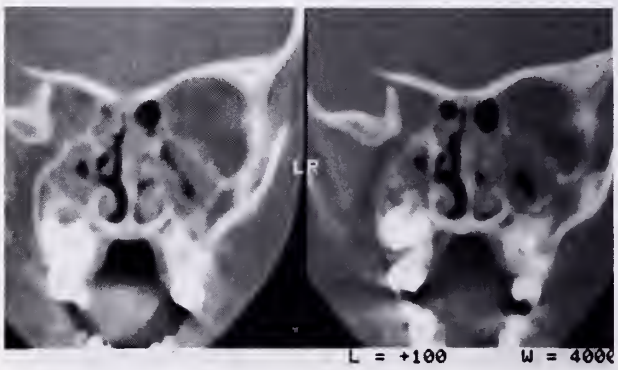


Figure 2 - Bilateral maxillary mucosal thickening with near opacification and mucosal thickening extending into the ethmoid cavity bilaterally. A small air pocket exists in the most posterior ethmoid cells.

Further examination is directed toward signs of allergy: eczema of the facial skin, allergic shiners and periorbital edema. Periorbital edema localized in the medial canthal area may also reflect acute ethmoid sinusitis. An occasional child will have purulent epiphora and conjunctival discharge. A foul smelling nasal discharge is sometime interpreted as halitosis.



Figure 3 - Turbinate hypertrophy of the right inferior turbinate, early polyp formation in the ethmoid cavities with mild opacification of the ethmoid cells posteriorly. The ostiomeatal complex is not seen in this view due to its postertior positioning.

Pharyngeal examination shows a purulent postnasal discharge with pooling in the lateral gutters an frequently there is lateral wall erythema.[2] Adenoid hypertrophy is frequently associated with chronic sinusitis as this causes nasal obstruction and stasis with secondary infection.

Chest examination often reveals diffuse rhonchi and occasional wheezes, usually secondary to the chronic drainage and aspiration.

Ear examination is essential as approximately 50% of children with sinusitis will have an associated otitis media.[2]

BACTERIOLOGY

The most common organisms found in pediatric sinusitis are *Hemophilus influenza, Streptococcus pneumonia* and *Moraxella catarrhalis.*[1,2] *Staphylococcus aureus* is found in 5-10% of sinus infection in children. The anaerobic organisms, Bacteroides and Fusobacterium, are occasionally seen. Appropriate cultures are difficult to obtain in the pediatric patient and nasal swab cultures may not correlate with those obtained from the sinus during a surgical drainage procedure.[1]

TREATMENT

Acute sinusitis

Acute sinusitis in a previously asymptomatic patient is treated with antibiotics to cover *H. Influenza, S. aureus* and *M. catarrhalis.* Generally amoxicillin, for fourteen days with associated decongestants will resolve the infrequent infection. Increased humidification, especially in winter months is beneficial. Lack of response to the initial treatment should be followed by a 2-3 week course of antibiotics with beta lactamase protection. Antibiotic penetration of the sinus mucosa and retained sinus secretions is extremely low,

accounting for the failure rate with short term treatment. Failure to respond to 4-6 weeks of appropriate therapy should prompt further evaluation or referral to an otolaryngologist.

Chronic Sinusitis

A child not responding to a 4-6 week course of appropriate antibiotics, decongestants and humidification is considered to have chronic sinusitis. At this point radiographic evaluation of the sinuses is indicated. Gross disease such as polyps, fluid and mucosal thickening involving the maxillary, frontal and sphenoid sinuses can usually be demonstrated on plain film radiographs, but these are grossly inadequate for evaluation of ethmoid sinus disease and ostiomeatal complex abnormalities. A coronal view CT scan is necessary for adequate evaluation of these areas and can demonstrate obstruction and other disease processes. It is also essential for evaluating the anatomic relationships of the nose, sinuses and skull base, an absolute must for the operating surgeon. Chronic disease with sinus opacification, polyposis, and ostiomeatal abnormalities are an indication for surgical intervention. The radiographic examination is enhanced by a thorough fiber-optic or telescopic examination of the nasal cavity with evaluation of the turbinate, lateral wall structures and the ostiomeatal complex. A thorough examination of the adenoid structures can also be accomplished and a determination made of the adenoid mass as a contributing cause of sinusitis.

Surgical Treatment

Surgical treatment is reserved for cases in which medical therapy has failed to resolve the infection. In these children simple antral lavage through the inferior meatus, with accompanying adenoidectomy, has been utilized to clear the sinus infection,[3] however, failure rates as high as 60% have been reported using this approach as this method does not address the problem responsible for or causing sinus obstruction and the resulting chronic infection.[4] The most recent surgical treatment, functional endoscopic sinus surgery, FEES, allows the surgeon excellent visualization of the nasal and sinus structures and direct control of the causes of ostiomeatal obstruction. With direct telescopic visualization the surgeon has better control of instruments and direct access to areas previously accessible only by extensive surgical approaches. The ostiomeatal complex may be opened, uncinate abnormalities corrected, diseased mucosa removed, and the natural maxillary ostium may be cleaned and opened. The sinus can then be directly visualized with the angled telescopes and diseased tissues or infectious drainage removed. This treatment approach is structured to preserve as much as possible the natural ostium and sinus mucosa and allow return of normal ciliary function which sweeps mucous, bacteria, and particulate matter out through the natural sinus opening into the nasal cavity. This decreases the chronic stasis and increases oxygenation of sinus tissues. This physiologic system is essential to normal sinus function and must be present for control of disease. This surgical modality does seem to be more effective in reducing the frequency and severity of sinus infections. Lusk[5] has shown a success rate of 85% with this technique.

If necessary the ethmoid cells can also be opened and drained by the endoscopic approach with more safety, precise tissue removal and minimal blood loss.

This surgery is usually done under general anesthesia in an outpatient setting and requires minimal postoperative medication. In some children a second anesthesia may be necessary 2-3 weeks following the surgery to remove clots and crust from the operative site and maintain a good opening into the sinuses.

At surgery cultures for aerobic and anaerobic organisms can be obtained to help determine an appropriate antibiotic regimen.

The endoscopic surgical approach allows for less tissue destruction with better long term results than the previous external approaches or inferior meatus window surgery. It causes fewer irreversible changes such as fibrosis, polyp formation and nonfunctioning cilia. This is particularly helpful in asthmatic children as it decreases the frequency and severity of the illness.

COMPLICATIONS

Complications of pediatric endoscopic sinus surgery include peri-orbital abscess and cellulitis, osteomyelitis, epidural and subdural abscess, meningitis and bronchopneumonia. Hopefully, early aggressive treatment of sinusitis in the child will lead to fewer complications and early resolution of the disease.

CONCLUSION

Kennedy[1] has proposed three principles in management of sinusitis:

1. Occlusion of the sinus ostia begins the cycle of chronic sinusitis, which over multiple episodes, without proper treatment, develops into chronic sinusitis.

2. Ostial blockage and stasis of secretions create a perfect bacterial culture medium, both aerobic and anaerobic.
3. Resolution of sinusitis is dependent on maintaining an open ostiomeatal unit. ❑

2630 Ridgewood Rd.
Jackson, MS 39216-4920

REFERENCES:

1. Kennedy D. First line of management of sinusitis: a national problem. *Otolaryngol Head Neck Surg*. November 1990;103(No.5,part2).
2. Baker, H. Bulletin of AAO/HNS, Committee of Infectious Disease, American Academy of Otolaryngology, January 1991.
3. Gross C, et al. Functional endoscopic sinus surgery in the pediatric age group. *Laryngoscope*. 1989:99.
4. Muntz H, Lusk R. Nasal antral windows in children: a retrospective study. *Laryngoscope*. June 1990:644-658.
5. Lusk R, Muntz H. Endoscopic sinus surgery in children with chronic sinusitis: a pilot study. *Laryngoscope*. June 1990:644-658.

Dr. Wallace is in the private practice of Otolaryngology: Surgery, Facial Plastic/Otolaryngology.

Employers Insurance, Inc.

INTRODUCES:
A+ Rated Companies
Low Major Medical Insurance

• GROUPS • INDIVIDUALS
• INDIVIDUAL DRUG CARD
Saves Up To 60%
• DISABILITY INSURANCE
• LIFE INSURANCE

Call Us For A Quote, Today!
366-7293
1-800-844-0093

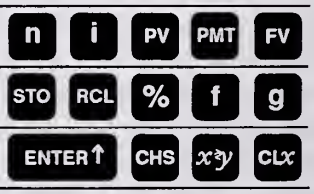
INVESTMENT MANAGEMENT
for
PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- No-Load Mutual Funds/Other Securities
- 23 Years Experience
- Tested Asset Allocation Model
- Fee-Only Advisor

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123



Partners In Health Care

Mississippi physicians and the public health system work together as partners. In December, we told you *why* and *how*. In January, we named names — we listed those of you in private practice who "partner" through contractual arrangements with the Department of Health.

This month, we remind you of the physicians who've chosen full-time, permanent positions with the public health team: Alton B. Cobb, state health officer; F. E. Thompson, state epidemiologist; Will Sorey, health services chief; District Health Officers James White, Reeda Lyons (consultant), Alfio Rausa, Thomas Waller, Don Grillo, Margaret Morrison, Robert Hotchkiss (consultant), Clay Hammack, and Robert Travnicek; Elizabeth Keeling, Blake Clinic; Cathy Stroud, Discovery Clinic; Mary Currier, epidemiology; Steven Moore, licensure consultant; Ken Pittman, perinatal consultant; and Robert Hotchkiss, TB medical director.

We must continue to work together and with our state's policy-makers to address identified but unmet needs.

Together, we can!

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

AMA Addresses Medicare Reform Issues

At its recent Interim Meeting in December, 1991 the AMA House of Delegates adopted the following policy statements to guide the Association with respect to the new Medicare RBRVS and other recent changes in the program.

1. That the American Medical Association take the position that the RBRVS-based Medicare physician payment schedule requires substantial improvements in many of its key elements and that the American Medical Association cannot endorse this new system until substantial improvements are made.

2. That the AMA publicize and seek to extend HCFA's grace period on the new visit codes an additional two months until April 1, that it continue its comprehensive program to educate physicians on the proper use of these codes, and that it work to ensure that HCFA engages in only educationally oriented profiling and review of the usage of these new codes until at least July 1,1992.

3. That the AMA undertake an immediate analysis of the implementation of the new Medicare payment schedule, with a focus on whether carrier implementation is consistent with Medicare law and HCFA regulations, especially with regard to calculation and application of the Adjusted Historical Payment Basis, and that the AMA take whatever steps are needed to correct and alleviate errors in the final schedule.

4. That the AMA reaffirm and continue efforts in support of its policy to prevent any further reduction of the current Medicare limiting charges (i.e., balance billing limits of 140% for evaluation and management services and 125% for all other services).

5. That the AMA seek a second Medicare participation decision period between June 1 and July 1, 1992 to allow physicians to reconsider the decision that they were forced to make in December 1991 on the basis of often limited information.

6. That the AMA expand its efforts to seek replacement of the current flawed proxy data basis for Medicare's geographic practice cost indexes (GPCIs) with current data that reflect actual practice overhead costs, that the AMA work to ensure that the professional liability component of both the GPCIs and the RBRVS more accurately reflects the actual cost experience of the physicians providing services to Medicare beneficiaries, including specialty-level differences in these costs.

7. That the AMA assign a continued high priority to legislative correction of grossly inequitable elements of Medicare physician payment policy as the lack of any payment for interpretation of EKGs, discriminatory payment reductions for "new" physicians, unfounded payment limits for the services of assistants-in-surgery, definition of "new" patients and the discriminatory 50 percent copayment for mental illnesses.

8. That the AMA establish a comprehensive program to monitor changes in patient access, physician practice patterns, and errors in carrier implementa-

tion under the new Medicare physician payment schedule, working closely with state and county medical societies, and that the AMA work with Health Care Financing Administration to correct all identified deficiencies in this program.

9. That the AMA seek to achieve adequate funding for Medicare Carriers as they implement the RBRVS.

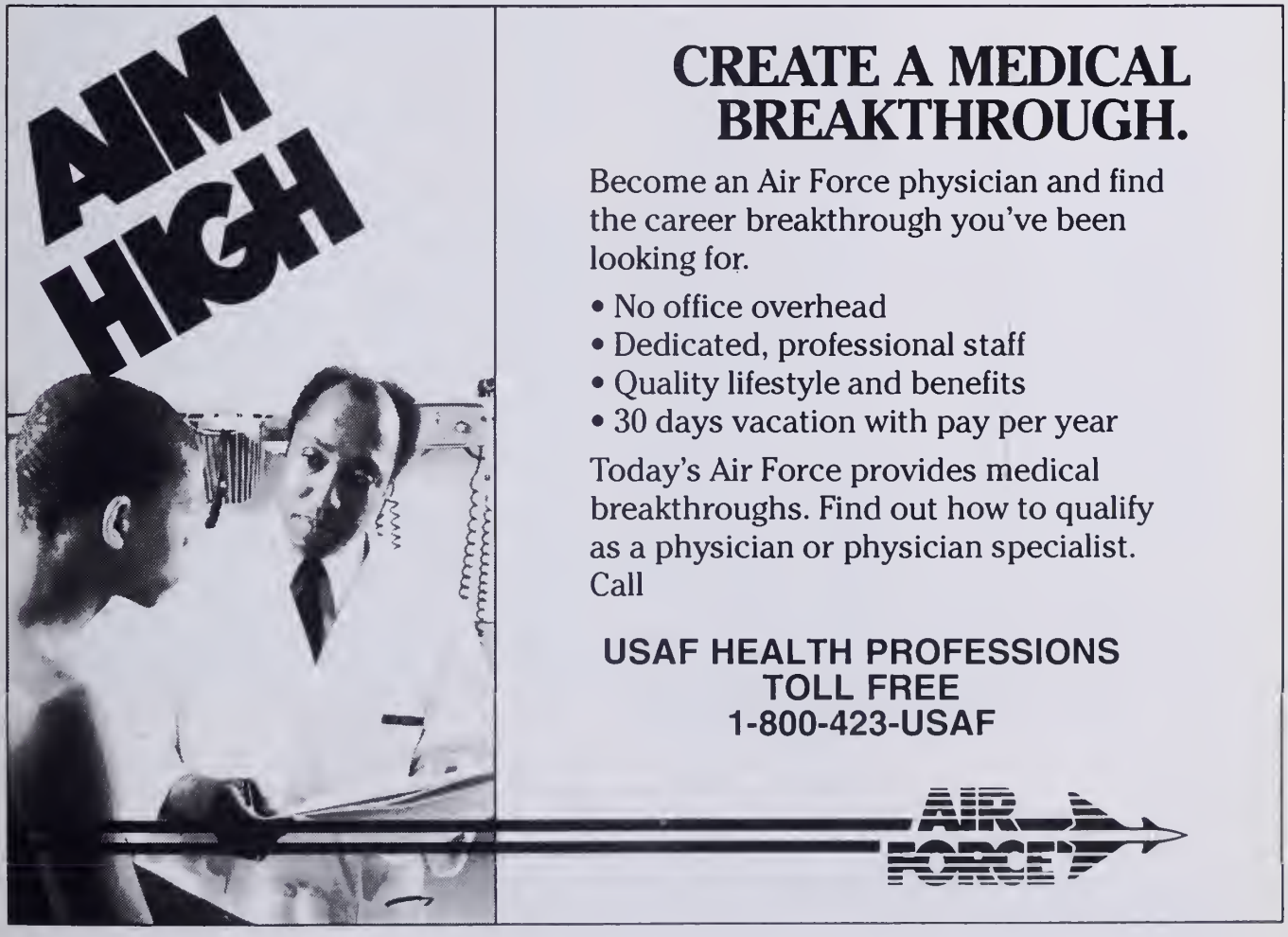
10. That the AMA work with HCFA and the national medical specialty societies to clarify HCFA's new global payment policy and to disseminate accurate information to physicians on these policies.

11. That the AMA Board of Trustees study and report to the House of the status and background of the "behavioral offset" and the "baseline adjustment" with an emphasis on the history of the use of these adjustments in Medicare Part B, including application to the RBRVS conversion factor and the MVPS.

12. That the AMA intensify its Payment Reform Education Project to provide all possible assistance to physicians as they adjust to and cope with the new Medicare payment schedule and that it evaluate the initial implementation of the new payment system, soliciting input from the entire Federation, and commenting, as appropriate, to HCFA as part of the 120-day comment period on the relative values for the new system and as otherwise appropriate.

In a related action the House also stated that the sole purpose of medical licensure is to assure the competence of physicians to practice medicine and voted to oppose any attempt to tie medical licensure to a physician's obligation to take part in any payment system or plan, including Medicare.

The AMA House of Delegates is composed of 442 credentialed delegates representing 54 states and territories and 81 national specialty societies. ❑





The President's Page

JAMES C. WAITES, MD

WILD DOGS AND WILDEBEEST

I have recently attended three meetings. Each one was different but ended up focusing on the changes occurring daily in our profession and the forces behind these changes. At the December AMA House of Delegates Meeting it was very apparent that the new RBRVS reimbursement system had many flaws which needed correcting, but was going to be implemented at Congressional direction in spite of the flaws.

We were later at a State Legislative Conference, which is held annually to acquaint state leadership with legislative initiatives being introduced across our nation. One of the most potentially scary is the issue of "Initiative and Referendum," which is being strongly supported in our State this year. On the surface this seems like something we would all support, but we also must remember that this method is being used in California, Washington, and several other states to introduce "Single Source Payor" forms of health reform, or in other words Statewide Comprehensive Health Care controlled by the State.

Then we had our own MSMA/Mississippi Hospital Association annual forum where we tried to inform our membership of our own plan "Health Access Mississippi" and of the problems facing each of us as the nation beings to debate its health policies. Dr. Tom Reardon from Oregon, an AMA Trustee and also a member of the Physician Payment Review Commission, was our special guest along with John Patchett from the AMA and several other speakers. I personally felt the day was very informative and was highlighted when our Governor Kirk Fordice spoke at our luncheon and his health plan was so closely parallel to our plan. But again by the end of the day we had been told of the outside forces impacting our profession.

In each meeting, as I tried to reflect my thoughts, this seemed to be the consensus -- health care costs are out of control and you doctors must get it under control. I recognize my own paranoia when I say this, but I am basically a very optimistic person and still am. I am reminded, however, of a National Geographic special that I watched recently on the Wild Dogs of Africa. It was

(Continued on page (53)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 2
FEBRUARY 1992

The Eagle Flies on the First

Yes, my little town of under 1000 population comes alive on the first of each month when the Eagle flies and those government checks roll in. I guess it's wonderful to have them because the whole town seems to blossom forth when they arrive. Well, almost, for you certainly can't tell it down here at the doctor's office.

Times are hard; the economy is down; 25% of our county is on welfare; and medicaid payments are years and years behind the times ..... I get $9.25 for emergency room visits. It is no wonder so many doctors do not accept it. I would not accept it either except for the fact that down here in rural Mississippi it is either that or nothing. And Medicare, you are not much better off. It has now gotten to the ridiculous point with the new levels of care: new CPT coding; complexities and confusion; and that never ending threat of criminal prosecution. It really makes you want to throw up your hands and quit! Oh, I almost forgot the RBRVS is coming and will be the saving grace. You can forget that, by the time the bureaucrats get through we'll be getting less money through some form of nationalized health.

The government wants more primary care physicians, but they certainly will not get them the way we are being treated now. I am tempted to turn all those provider numbers back to Medicare and Medicaid, but somewhere along the way I got used to eating. Surely the Eagle files more and more each month, but what good does it do for us as physicians. I don't want to shoot the "Eagle" down, I'd just like for him to fly my way sometimes.

Thank God I am a physician.

Joseph E. Johnston, MD
Associate Editor

Presidents's Page

(Continued from page 52)

fascinating to see them attack a herd of wildebeest, separate out one, and then feast on the kill. That is exactly my impression of what is being done to our profession. We are being attacked on all side in an attempt to separate us from the group. As soon as we split off or fall out, we are ready for the kill and will be feasted on. In my career I have never felt so keenly that we must be united in singleness of mind. Even those who try to distract us from the problems admit that we provide good quality efficient care but they would control the system. We must recognize that there will be negotiations on our behalf. I believe we are best served by a strong federation of State Societies united into the AMA representing all of us.

It is certainly true that change is coming, it is not an option, but our growth and professionalism is an option. We must therefore stand firm on our ethics and stand up for what is best for our patients.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Letters

To The Editors, Journal MSMA:

This letter is in response to recent articles in various medical journals, including JAMA, relating to breast conservation surgery "BCS" for breast cancer. Many of these articles have noted that the number of patients who are treated for breast cancer with BCS followed by irradiation has not significantly increased over the past several years. The authors of these papers seem perplexed when confronted with this fact especially in light of the encouragement and support for breast conservation surgery coming from several large and respected centers.

Several of the papers of BCS over the past several years have been authored by those who have an interest and expertise in one form of therapy or another. These authors are quite naturally biased somewhat toward their own general methods of approach to management of breast cancer. Other authors seem to be analyzing statistical data only.

The difficulties associated with a practicing physician's recommendation to the patient who has a diagnosis of breast cancer is greatly compounded by the lay interpretation of the current literature on treatment of breast cancer, especially that relating to "lumpectomy" versus mastectomy.

As a general surgeon with a practice limited to diseases of the breast I utilize an approach for patients which seems to work satisfactorily and which allows them to be well informed and to participate in the decisions regarding management of their cancer.

Once the patient has a firm diagnosis of breast cancer, including the cell type, location, relative size of the tumor to the breast, the approximate percentage of intraductal component of the tumor, proximity to the nipple areolar complex, evidence of multifocal disease, all coupled with the patients individual history and know risk factors, a discussion is held with the patient regarding the appropriate treatment. For purposes of this discussion we treating physician's must formulate our own opinions based on education, training, and experience as to the relative weight of importance of these factors and others in planning therapy for breast cancer.

In order to best advise the breast cancer patient as to the options for treatment, the physician who diagnoses and evaluates the individual case must first satisfy himself that this patient, at least statistically, should have comparable results, as regards to local/regional control of breast cancer with either a mastectomy of BCS. After all, local/regional control is the only aspect of treatment that surgery of any sort can address. Once the physician is confident that this patient truly would have, from a statistical point of view, comparable results with either procedure, then a detailed discussion covering the following points should ensue:

1. Based upon our current knowledge of breast cancer, no matter which treatment option is selected, the entire breast on the affected side must receive treatment in one fashion or another either by surgical removal or irradiation of any remaining breast tissue.
2. No matter which option (BCS or mastectomy) is selected, either of these entail the removal of lymph nodes from the corresponding axilla. I find that this fact is unknown to many women relating to the BCS.
3. Either procedure will require follow-up and possible further treatment based on analysis of tissue removed during the surgical procedure. The follow-up after mastectomy will not require further evaluation of the affected breast, for it will be absent. However, in the case of irradiation to the remaining breast tissue after BCS, there will need to be very vigorous and detailed follow-up of the irradiated breast for the possibility of recurrence. This will be somewhat, complicated by the expected changes in the breast tissue due to irradiation.
4. It is important to stress that there is no evidence available to suggest that breast conservation surgery is <u>better</u> treatment than mastectomy in any case of breast cancer from the standpoint of local or regional control of the disease. Indeed, any such suggestion would have to be carefully evaluated.

With these facts in mind, then the patient can participate in the decision as to which option to select.

Why would a patient choose to have BCS? This choice would have to be based on the individual patient's attitude as relating to cosmesis and the psychosexual aspect of maintaining an anatomical breast mound. This choice should not be based on any misconception that the breast conservation therapy is better from the standpoint of local or regional control, prevention of distant spread, less expensive, or requires less follow-up. The choice certainly should not be based on the physicians personal attitude toward cosmesis of the psychosexual aspect of loss of a breast. Actually it has been shown that the breast conservation therapy expenses are approximately the same as mastectomy, possibly more, and that the follow-up is definitely more complicated as one must consider the irradiated breast as a significant potential site for recurrence.

It simply boils down to this: In some women their attitude toward the appeal of maintaining a breast mound and/or the psychosexual implications of mastectomy are of such importance to them that they select breast con-

servation therapy. For these patient's, breast conservation therapy (BCS) is definitely the best procedure. However, there are many women who feel that as far as cosmesis is concerned, it is simply not important to them to have an anatomical breast mound present and in addition they realize that they can have reconstructive surgery later if desired. For others, they simply attach no psychosexual importance to their breast and therefore these patients do no choose to have the conservative therapy. It seems that when practicing physicians can knowledgeably and objectively form an opinion as to the relative merits of each procedure as related to their individual patient and then convey this information to the patient in the proper perspective, that the patients themselves often choose mastectomy rather than breast conserving surgery or "lumpectomy".

The "under utilization" of BCS may not be due to the lack of information among the treating physicians or a lack of understanding of the procedure, but the result of informed reasonable and practical consideration of the options by the patient as well as the physician.

Donald A. Hopkins, MD, FACS
The Breast Disease Clinic
Gulfport, Mississippi

To The Editors, Journal MSMA:

I would like to respond to the article in January's issue concerning Health Access in Mississippi. I feel, overall, that the plan is a sound one and that recommendations for basic, minimal health coverage that could be offered through small employers are excellent.

There was, however, one glaring omission, in my opinion. No mention was made of insurance coverage for nervous and mental disorders. MSMA's own group policy provides a lifetime maximum benefit of $10,000 for these disorders, which is so low as to be ludicrous. Our state passed an insurance bill which went into effect in July of 1991 requiring a minimum $50,000 lifetime maximum - however, on inquiry, MSMA has informed me that because this is a self-insured program, they are not required to increase the benefit amount - evidently a loophole left in this recent legislation.

Adequate treatment for such biologically based mental disorders as schizophrenia, bipolar disorder, degenerative dementia, obsessive compulsive disorder and major depression commonly generate costs to the patients and their families well in excess of $10,000 in a lifetime. Diversion to the public mental health system provides less than adequate care due to underfunding and understaffing of these programs.

Advances in the understanding of these disorders continue to reveal that these are "diseases" too, and there are many who feel that the current practice of placing strict limitations on mental and nervous disease coverage is discriminatory.

There has long been a subtle prejudice against the specialty of psychiatry in organized medicine. I generally take a fairly sanguine attitude, knowing that the average medical or surgical practitioner experiences a good deal of frustration in dealing with my "type" of patient. But when it comes to the setting of policy, I feel I have an obligation to my patients to voice my opinion that their needs not be ignored by organized medicine.

Elizabeth C. Henderson, MD
Jackson, Mississippi

The Delta Region AIDS Education and Training Center grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN
Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street
Jackson, MS 39216-4505



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

"Current Opinions" of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON PRACTICE MATTERS

Informed Consent

The patient's right of self-decision can be effectively exercised only if the patient possess enough information to enable an intelligent choice. The patients should make his own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for his care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is basic social policy for which exceptions are permitted (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

Laboratory Services

(1) A physician should not misrepresent or aid in the misrepresentation of laboratory services performed and supervised by a non-physician as the physician's professional services. Such situations could involve a laboratory owned by a physician who directs and manages its financial and business affairs with no professional medical services being provided; laboratory work being preformed by technicians and directly supervised by a medical technologist with no participation by the physician; or the physician's name begin used in connection with the laboratory so as to create the appearance that it is owned, operated, and supervised by a physician when this in not so.

(2) If a laboratory is owned, operated, and supervised by a non-physician in accordance with state law and performs tests exclusively for physicians who receive the results and make their own medical interpretations, the following considerations would apply:

The physician's ethical responsibility is to provide his patients with high quality services. This includes services which he performs personally and those which he delegates to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician or non-physician, unless he has the utmost confidence in the quality of its services. He must always assume personal responsibility for the best interests of his patients. Medical judgement based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides him with low cost laboratory services on which he charges the patient a profit, is not acting in the best interests of his patient. However, if reliable, quality laboratory services are available at lower cost, the patient should have the benefit of the savings. As a professional, the physician is entitled to fair compensation for his services. A physician should not charge a markup, commission, or profit on the services rendered by others. A physician should not charge for services that are not provided. A markup is an excessive charge that exploits patients if it is nothing more than a tacked on amount for a service already provided and accounted for by the laboratory. A physician may make an acquisition charge or processing charge. The patient should be notified of any such charge in advance.



ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

AXID®
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

1. Data on file, Lilly Research Laboratories. *See accompanying page for prescribing information.* © 1991, ELI LILLY AND COMPANY NZ-2947-B-249304

AXID®

nizatidine capsules



Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer* – for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy* – for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)* – for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 fU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

c 1991, ELI LILLY AND COMPANY



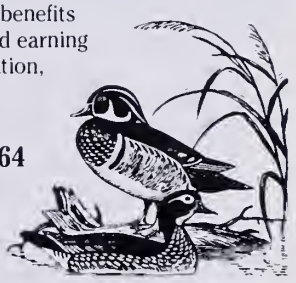
Orthopaedics

Outstanding opportunity for an Orthopaedic Surgeon to join a thriving practice in a community of 68,000 near Little Rock. Very busy orthopaedist affiliated with a large, state-of-the-art facility seeks an associate for his practice. Opportunity to practice general orthopaedics and develop subspecialty interests.

New orthopaedic offices, with over 3,300 square feet are located in the new medical tower adjoining the medical center and are equipped with the latest technology.

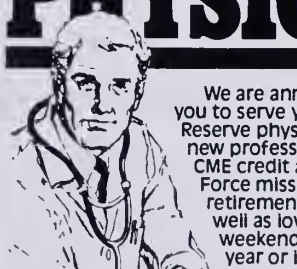
Good call coverage from other orthopaedists, as well as a good base of physicians for back-up and referrals.

Generous compensation and benefits package. Excellent growth and earning potential. For further information, contact:



Greg Foster
1 (800) 626-1857, ext. 264
Suite 250, Browenton Place
2000 Warrington Way
Louisville, KY 40222

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (404)421-4892

Or Fill Out Coupon and Mail Today!
To: SMSGT Hartung
14 AF/RSH
Dobbins AFB, GA 30069

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE

A GREAT WAY TO SERVE

American Medical Association

Physicians dedicated to the health of America

For Your Benefit

Materials included are excerpted from *Member Matters*, a monthly publication sent to all members of the American Medical Association. *For Your Benefit* is provided by the American Medical Association.

AMA Pushes for, Obtains Visit Code Grace Period

The American Medical Association has strongly argued with HCFA that physicians need more time to familiarize themselves with the new CPT visit codes, and that HCFA needs to provide a grace period that is national in scope.

Although the new 1992 CPT-4 visit codes are effective January 1, 1992, HCFA has announced a 60-day grace period for physicians to become acquainted with the new visit codes.

For services given January 1 - February 29, carriers will accept and pay claims for 1991 visit codes at 1991 payment amounts.

For services given March 1 and after, carriers will deny assigned claims with 1991 visit codes.

For unassigned claims, contractors will contact physicians to obtain the correct codes.

To avoid delays in claims processing that will change so dramatically this year, especially for Evaluation and Management codes, get your copy of *CPT 1992* by calling toll-free 1-800-621-8335. OP 054192

AMA Continues to Work on RBRVS Implementation

Since the release of the new Medicare RBRVS payment system regulation, we at the AMA have heard your concerns and will respond by expanding and refocusing our advocacy efforts on your behalf.

During the next several months, the AMA will focus and expand its activities emphasizing assistance to you as well as legislative and regulatory relief. Some specifics of the plan are:

- developing concensus on legislative and regulatory priorities based on input from state, specialty and group practice advisory committees;
- intensifying lobbying and grassroots activities for EKG interpretations; eliminating new physician cuts; and increasing payments for assistants at surgery;
- developing 1993 recommendations for Medicare MVPS and conversion factors;
- pursuing relief on balance-billing limits;
- seeking expedited adoption of new visit codes by state Medicaid agencies; and
- urging HCFA to refine Geographic Practice Costs Indicies (GPCIs) for malpractice and office overhead.

Substance Abuse: AMA Fights Legal and Illegal Killers

Between 40 and 50 million Americans smoke. And over 400,000 die each year from tobacco-related disease alone. Even people who don't smoke are affected. Passive smoking kills as many as 53,000 nonsmoking Americans every year. This abuse drains over $90 billion a year in medical expenses and lost productivity and wages.

Now add in the toll of alcohol and drug abuse.

Alcohol abuse cost our economy $33 billion in lost earnings each year; drug abuse tops $7 billion.

The toxicity of alcohol and drug abuse spreads into all areas of American life including family violence and crime. According to studies, 54% of prisoners admit to being under the influence of drugs at the time of their offense. In 1989, 45% to 83% of those arrested tested positive for one or more drugs.

What is the AMA doing?

The American Medical Association and its membership support a tobacco-free society by the year 2000.

The AMA has helped ban smoking on airplanes, began a mandate for smoke-free hospitals, and supported the Environmental Protection Agency in its classification of passive-smoke as a known-cause of cancer.

Reducing smoking among our nation's children, young women, minorities and those Americans with less formal education was the dominant issue of the "Final Report: Tobacco Use in America." Another key concern is the need for public policy- makers to recognize the powerfully addictive nature of nicotine which the report covers in its section on legislative and activist strategies.

The AMA supports efforts to ban and/or restrict tobacco advertising and promotion. We work to restrict teenagers' access to tobacco products by banning vending machine sales, raising the legal age of purchase to 21 and halting cigarette give-away promotions.

The AMA's policy-setting House of Delegates has gone to bat against smoking by opposing the tobacco industry's lucrative sponsorship of sports by calling for:

- major league baseball owners to ban smoking in parks,
- stopping tobacco company sports sponsorship and advertising, and
- cigarette warnings that say: "Smoking is ADDICTIVE and may result in DEATH."

In the continuing war on drugs and alcohol, the AMA supports its physicians' local efforts by publishing material to help physicians identify and evaluate drug abuse in their young patients and by developing a training program for physicians dealing with patients at high risk of drug abuse.

The AMA also works with federal and state enforcement agencies to create model systems to prevent prescription drugs from being diverted to "street" markets and drug abusers.

Working with the American Bar Association, the AMA is helping to educate junior high school students on the grim consequences of drug and alcohol abuse.

And, the AMA has demanded that alcohol advertising bear warning labels.

What can you do?

To battle tobacco use, support efforts to protect nonsmokers from passive smoke; urge your local pharmacist to refrain from selling tobacco products; encourage school systems to become smoke-free; ask for nonsmoking restaurant seats, hotel rooms and rental cars; and write the publishers of magazines and newspapers to remove tobacco advertisements.

To combat drug and alcohol use, teach healthy lifestyles by example.

For all of us, the value of real-life experiences and achievement are the durable mainstays of pleasure and fulfillment.

Medical Organization

MSMA HOUSE OF DELGATES' NON-SMOKING RESOLUTION GETS ACTION

When the MSMA House of Delegates met in April, 1991, a resolution on the designation of non-smoking areas in restaurants was referred to the Council on Legislation. This resolution stated that the Council on Legislation would initiate and support legislation requiring that restaurants designate non-smoking areas within their facilities.

Because of the unlikelihood of the passage of such legislation, the Council requested that the Board of Trustees ask the Mississippi State Board of Health to issue a regulation encouraging non-smoking areas in restaurants, since the Board of Health licenses and regulates all restaurants and has the authority to issue such a regulation.

On December 17, 1991, State Health Officer, Dr. Alton B. Cobb, presented a resolution to the Mississippi Board of Health. The board adopted the resolution, which will be presented to the Mississippi Restaurant Association. This resolution stated that the State Department of Health and the Restaurant Association will work cooperatively to encouraged restaurants to provide for their patrons a non-smoking area reasonably calculated to address the needs of the non-smoking public; that restaurants be encourage to display prominently a sign indicating their policy on seating smokers and nonsmokers and make their seating availability known; and that restaurants be supported in their efforts to designate all of their indoor seating as a non-smoking area if they so choose. Restaurants seating thirty or less and private social functions are exempted from the provisions of this resolution.

In conjunction with this resolution, the Office of Health Promotion and Education at the MS Department of Health is sponsoring an ad in several newspapers throughout the state recognizing restaurants which have voluntarily designated at least one-third of their seating capacity as non-smoking areas. Healthy Heart and Lung Certificates signed by the State Health Officer will be issued to each restaurant. The ad will encourage all restaurants with non-smoking seats to contact the Department of Health for information and technical assistance. The Mississippi Council for a Tobacco Free Society, consisting of the Mississippi Chapters of the American Cancer Society, American Lung Association, and American Heart Association have endorsed the ad. ❑



MSMA CONDUCTED EVALUATION AND MANAGEMENT CODING WORKSHOPS DURING JANUARY

Six workshops on proper coding of the new HCFA revised Evaluation and Management Codes (visit codes) were held in the state during January. Approximately 650 physicians, medical office managers and staff attended these sessions. Speakers for the workshop included, Ann Peden, M.B.A., R.B.A., assistant professor, School of Health Related Professions, University of Mississippi Medical Center, and Martha Barrett, Manager, Provider Services Department, Travelers Medicare, both of Jackson. Ms. Peden presented in-depth step-by-step instruction on the use of the new codes as well as instruction on the new defined levels of care. Ms. Barrett provided information on the changes that will be implemented this year in the Medicare program and explained the sample audit process which will be used to determine if physicians are properly using the new visit codes.

In November of 1991, MSMA conducted four workshops on RBRVS and Medicare Payment Reform for physicians and their office personnel. ❑

SUMMARY OF BOARD OF TRUSTEES MEETING DECEMBER 14, 1991

The MSMA Board of Trustees held its regular Fall meeting in Jackson on Saturday, December 14. The following Officers and Board members were in attendance: **James C. Waites, M.D.**, Laurel, President; **William C. Gates, M.D.**, Columbus, President-Elect; **J. Elmer Nix, M.D.**, Jackson, Immediate Past President; **Don Q. Mitchell, M.D.**, Jackson, Secretary-Treasurer; **H. Vann Craig, M.D.**, Natchez, Speaker of the House; **Fred L. McMillan, M.D.**, Jackson, Chairman, Board Member, Dist. 4; **Mal G. Morgan, M.D.**, Natchez, Vice Chairman, Board Member, Dist. 7; **Stanley A. Wade, M.D.**, Meridian, Secretary, Board Member, Dist. 5; **Michael H. Carter, M.D.**, Greenwood, Board Member, Dist. 1; **Stanley Hartness, M.D.**, Kosciusko, Board Member, Dist. 2; **Leonard H. Brandon, M.D.**, Starkville, Board Member, Dist. 3; **John Paul Lee, M.D.**, Forest, Board Member, Dist. 4; **David L. Clippinger, M.D.**, Gulfport, Board Member, Dist. 8; and AMA Delegates Carl G. Evers, M.D., Jackson; **J. Edward Hill, M.D.**, Hollandale; and **Sidney O. Graves, M.D.**, Natchez.

A summary of subjects considered by the Board and actions taken follows:

* Reviewed the program for the January 21, 1992 Socioeconomic Forum and Legislative Reception to be conducted in Jackson.

* Received a report on the MSMA/MS Bar Association sponsored drug education program for youth.

* Reviewed proposed changes in the *MSMA Membership Directory* and approved voluntary inclusion of members' home telephone numbers.

* Noted efforts to join the MS Hospital Association in seeking improvements in the legal shelter provided hospital medical staff disciplinary proceedings.

* Approved a resolution commending the Director of the MS Medicaid Program, Ms. Helen Wetherbee.

* Heard plans to continue to monitor regulations dealing with reimbursement of maternal and child care services under Medicaid.

* Adopted a "Health Access Mississippi" report and directed that it be publicized to the MSMA members and members of the legislature.

* Received a report on candidate support activities of the MS Medical Political Action Committee (MMPAC) during the recent state elections. The Board noted that almost 80 percent of the candidates supported by MMPAC were elected.

* Considered methods to publicize the development of parameters

Board Summary Continued

of care to the MSMA membership, both at the association's annual session and at hospital medical staff meetings.

* Appointed a committee to study and recommend a standardized form for sports preparticipation exams.

* Heard a report from the State Health Officer, Dr. Alton B. Cobb, concerning the activities of his department particularly dealing with recruitment of physicians to practice in rural areas and funding for local health clinics.

* Heard a report on MSMA membership recruitment activities.

* Received the annual budget recommendations of the Council on Budget and Finance and approved 1992 operating budgets for MSMA and its affiliated organizations.

* Reviewed a report on plans for the 124th MSMA Annual Session to be conducted at the Ramada Renaissance Hotel in Jackson, April 29-May 3, 1992.

* Heard a report from Dr. R. Faser Triplett, President, Medical Assurance Company of MS, concerning the company's current activities.

* Received a report from the association's delegates to the AMA's December, 1991 meeting, which among other topics, presented the AMA's position on the Medicare RBRVS, AIDS and physician ownership of medical referral facilities.

* Heard a report from Dr. Frank Morgan, Executive Director, MS Board of Medical Licensure, regarding the Board's licensure and disciplinary activities.

* Reviewed the association's program to promote a school health curriculum and plans for a Teen Health Education Seminar in the Spring of 1992.

* Heard the status of implementation of the Medicare RBRVS and plans for workshops for association members and their employees in January on new CPT procedure codes.

* Heard a report from Mrs. Sylvia Walker, President, MSMA Auxiliary, regarding the Auxiliary's activities in support of AMA-ERF contributions, a Teen Health Education Seminar and health legislation.

* Appointed a committee to study physician recruitment and placement activities in Mississippi and how MSMA can support such activities.

* Heard a report from Dr. Ellis Moffitt, Chairman, MSMA Disabled Physicians Program, regarding the current activities and status of the program.

MSMA members may obtain further details about any subject considered by the Board of Trustees at its December 14, 1991 meeting by contacting the MSMA office in Jackson.

"DOCTOR OF THE DAY" FOR THE 1992 LEGISLATIVE SESSION

Forty MSMA physicians have volunteered to serve as **"Doctor of the Day"** during the 1992 Legislative Session. Serving as doctor of the day is a unique way in which physicians can enhance their visibility with legislators.

With a parking space reserved on the Capitol grounds for convenience, physician volunteers begin their day at the Capitol around 9:00 a.m. The Emergency Medical Care Unit located on the ground floor room 116 serves as headquarters. The unit is staffed by Mavis Barlow, R.N., who has served in this capacity for the past 23 years. Ms. Barlow is employed by MSMA each year during the legislative session.

In addition to being on call for any medical problems that may arise, physicians have the opportunity to watch both the Senate and the House of Representatives when in session, observe legislative committee meetings where issues concerning medicine are addressed and personally visit with senators and representatives. The doctor's day at the Capitol concludes about 5:00 pm. ❑



*MSMA President-Elect **William C. Gates, MD** of Columbus is pictured here in the Emergency Medical Care Unit at the Capitol when he served as "Doctor of the Day".*

If you have not signed up to serve as "Doctor of the Day" and would like to, please contact the MSMA office, 1-800-898-0251.



*MSMA President, **James C. Waites, MD** of Laurel served as "Doctor of the Day" on the opening day of the 1992 Legislative Session. **Ms. Mavis Barlow, R.N.**, pictured here with Dr. Waites, staffs the Emergency Medical Care Unit on a daily basis.*

1992 SOCIO-ECONOMIC AND LEGISLATIVE FORUM HELD JANUARY 21.

The MSMA Legislative Forum, held at the Ramada Coliseum, began at 10:00 am with the opening of the MSMA House of Delegates. MSMA Speaker of the House, Vann Craig, MD of Natchez, called the session to order, then introduced MSMA President, James C. Waites, MD who presented highlights of the *Health Access Mississippi* plan to the House of Delegates. *Health Access Mississippi* is a comprehensive plan to improve access to quality, affordable health care in the state of Mississippi by addressing the following key issues: Health Insurance Reform, Medicaid Enhancement and Expansion, Increasing the Availability of Care in Rural Areas and Health Care Cost Containment. Dr. Waites stated that copies of the plan had been mailed to legislators, members of state and local government, businessmen, business associations, and the media. This was done in an effort to stimulate discussion and planning to assure quality heath care for all Mississippians. Copies of the document were available to all members of the House of Delegates in addition to being published in the January issue of the *Journal MSMA*.

MSMA Vice Speaker, Eric McVey, MD of Jackson, introduced George E. McGee, MD, Chairman, of the Council on Legislation, who presented the recommendations for the 1992 legislative program. Dr. McGee stated that the political climate in Mississippi today is rather unpredictable because of the sweeping changes made at the polls this past year in addition to the many problems already facing legislators in the 1992 Legislative Session.

In accordance with actions of the MSMA House of Delegates, Board of Trustees and the Council on Legislation Dr. McGee, reported that the association will pursue legislation in the 1992 session to:

- require any health insurance company to honor an insured's assignment of benefits to a physician;
- amend the law requiring notification of the provider whenever an insurance company pays the insured directly to clarify when a charge for the "Explanation of Benefits" can be levied; and
- require restaurants to designate non-smoking areas and prohibit smoking in all pubic and private schools.

AMA Trustee, Thomas R. Reardon, MD of Oregon, was a special guest speaker. In 1986 Dr. Reardon was nominated by the AMA to serve on The Physician Payment Review Commission to which he was appointed. In 1991 he was reappointed for another three-year term. Dr. Reardon is widely considered to be the voice of the practicing physician on the Commission and he has become one of the most knowledgeable people in the country on the subject of physician payment and the Medicare RBRVS. Dr. Reardon spoke to the MSMA House of Delegates about plans of both the AMA and the Physician Payment Review Commission to address the problems with the Medicare RBRVS. He also discussed what he thought to be the future role of both the AMA and the Commission in physician payment.

Governor Kirk Fordice addressed the Luncheon session. His comments centered mainly around the



***Robert C. Clingan, MD** a Dermatologist from Vicksburg, asked questions concerning access to health care in Mississippi during the MSMA House of Delegates .*

findings of the task force on healthcare which he appointed shortly after his election. Governor Fordice stressed that the number one problem, as he saw it, was cost.

Other guest speakers included Walter McClure, PhD, President of the Center for Policy Studies, Minneapolis, Minnesota; Alicia Pelrine, National Governor's Association; John E. Patchett, JD, Director of the Department of State Legislatures, American Medical Association; and Henry J. Ernstthal, JD, CAE, Executive Director of the Master of Association Management Program, George Washington University, Washington, D.C. ❑



A large crowd, above, enjoyed the reception for legislators.



The Honorable Kirk Fordice, Governor, State of Mississippi, above, was the guest speaker for the MSMA Legislative Forum luncheon.

AMA Trustee, Tom Reardon, MD, below right, answered questions from members of the MSMA House of Delegates after his presentation on physician payment reform; Vann Craig, MD, MSMA Speaker of the House, left, presided over the session.





***George E. McGee, MD** of Hattiesburg, Chairman of the Council on Legislation, at the podium, presented the 1992 Legislative Program to the MSMA House of Delegates.*

IT TOOK YOU MANY YEARS TO BECOME A PHYSICIAN...

MPIC
Mississippi State Medical Association Sponsored Insurance Plans

Why spend one more minute looking for LIFE INSURANCE?

The Mississippi State Medical Association, Manhattan National Life, and BellMED Insurance Resource Center Inc., have joined together to offer MSMA endorsed SIMPLIFIED ISSUE Term Life plans. Our current SUPERSAVER XV long term, low cost plan offers MSMA members, their staff and spouses these benefits...

★ **GUARANTEES**

— In these days of economic and financial uncertainty, we are pleased to offer you a 15 YEAR RATE GUARANTEE

— Your premium stays level and cannot be increased for the next 15 years...and that's guaranteed

— The coverage is guaranteed renewable to age 95

★ **SIMPLIFIED ISSUE**

— NO EXAM or BLOODWORK*

— NO SALESPERSON VISIT

— ONE PAGE APPLICATION

★ **VERY LOW RATES**

— example: $200,000 preferred non-smoker — annual rate guaranteed for 15 years

Age 40	=	**$400**
Age 45	=	**$554**
Age 50	=	**$800**

IF YOU HAVE ALREADY TAKEN ADVANTAGE OF THE PROGRAM...*THANK YOU!*

BELLMED

If you have not, we think SIMPLIFIED ISSUE SuperSaver XV makes sense. For rates and information, call BellMED at

1-800-456-8042

Manhattan National Life

*Manhattan National Life does reserve the right to request additional information.

What employers — like doctors — are asking Employer Plus.

Q. ***Should an employer provide benefits for employees, or just give them a raise in pay and let them fend for themselves?***

A. *If a pay raise is given, it will cost you as the employer additional dollars by increasing the employer matching social security taxes and increasing worker's compensation premiums. However, if you provide them with employer paid benefits, you will not incur these additional costs.*

Q. ***Will my employees settle for benefits rather than pay increases?***

A. *A study done by the Harvard Business School during the late 80's found that employees rated increased benefits as the next best thing to a raise in pay.*

How Employer Plus can help!

Good benefits help to retain good employees. And, if you split the cost of the benefits with the employees, both of you will come out ahead.

Here's why.

Employer Plus offer our clients an IRS Qualified "Section 125 Cafeteria Plan" for their employees' benefits plan. This plan allows each employer to withhold a portion of its employees' salary to be used to pay for insurance premiums, medical expenses, dependent care, and savings for retirement. The amount that each employee sets aside from their salary to pay for these benefits is tax exempt from FICA Withholdings, Federal Income Tax Withholdings and State Income Tax Withholdings.

In doing this, a bigger take-home amount is produced for your employees, even though you the employer have not actually given them a raise. The increase simply comes from the amount that employees' were paying the government in tax dollars.

Here is just a sample of the benefits that Employer Plus offers our clients in our Cafeteria Plan. All of these benefits are with top-of-the-line, national companies:

- **Health Insurance**
- **Dental Insurance**
- **Vision Insurance**
- **Disability Income Insurance**
- **Life Insurance**
- **Dependent Care**
- **Medical Reimbursement**
- **Retirement Plans**
- ***... and more***

Employer Plus has saved the best part for last...

Our Cafeteria plan will lower your labor cost. For every dollar that your employees run through the Cafeteria Plan — you the employer — will save 7.65%, because you will not have to pay the employer matching share of social security tax. Also, worker's compensation premiums are not calculated on benefit bonuses.

If you are interested in giving more to your employees — and taking home more money from your practice — give us a call.

We have many ways we can save you money!

Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720

New Members

Cannella, Dominic Michael, Hattiesburg. Born Tampa, FL, on December 28, 1957; MD, University of South Florida College of Medicine, Tampa, FL, 1982; interned one year University of Mississippi Medical Center, Jackson, MS; neurosurgery residency State of University of New York at Buffalo, Buffalo, NY, 1986-89; neurology fellowship Harvard Medical School, Boston, MA, 9/89 - 12/89; elected by South Mississippi Medical Society.

Cheatham, David H., Gulfport. Born San Antonio, TX, February 5, 1953; MD, Medical University of South Carolina College of Medicine, Charleston, SC, 1978; interned and pediatric residency, Emory University, Atlanta, GA, 1978-81; elected by Coast Counties Medical Society.

Dayton, Harry E., Meridian. Born March 9, 1945; MD, Case Western Reserve University School of Medicine, Cleveland, OH, 1982; interned and medicine residency University Hospitals, Cleveland, OH, 1982-85; cardiology residency, same, 1985-87; elected by East Mississippi Medical Society.

Hill, David R., Whitfield. Born April 29, 1954; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; interned one year University Medical Center, Jackson, MS, and one year residency psychiatry; elected by Central Medical Society.

Kahlon, Ravinder, Jackson. Born September 24, 1959; MD, Government Medical College Amritsar, India, 1980; neurology and psychiatry residency University Medical Center, Jackson, MS, 1986-91; elected by Central Medical Society.

Miller, Mary C., Jackson. Born Greenwood, MS, March 27, 1954; MD, University of Mississippi School of Medicine, Jackson, MS, 1979; interned and family practice residency, University Medical Center, Jackson, MS, 1979-82; elected by Central Medical Society.

Salkind, Alan R., Jackson. Born Los Angeles, CA, February 1, 1954; MD, East Tennessee State University, Johnson City, TN, 1985; interned and residency in Internal Medicine and Infectious Diseases, Albany Medical Center, Rochester, NY, 1986-91; elected by Central Medical Society.

Sachitano, Richard A., Biloxi. Born New Orleans, LA, September 30, 1946; MD, Louisiana State University School of Medicine, New Orleans, LA, 1983; interned and pathology residency Alton Ochsner Medical Foundation, New Orleans, LA, 1983-87; elected by Coast Counties Medical Society.

Sauls, F. Clark, Hattiesburg. Born Hattiesburg, MS, August 1, 1952; MD, Louisiana State University School of Medicine, New Orleans, LA, 1977; general surgery residency Mayo Graduate School of Medicine, Rochester, MN, 1979-84; cardiothoracic surgery fellowship, University of Maryland, Baltimore, MD, 1984-86; elected by South Mississippi Medical Society.

Stretch, T. Brian, Natchez. Born Urania, LA, March 28, 1958; MD, Louisiana State University School of Medicine, New Orleans, LA, 1986; pediatric residency Earl K. Long Hospital, Baton Rouge, LA, 1986-89; elected by Homochitto Valley Medical Society.

Thompson, Catherine A., Bolton. Born Bolton, MS, August 22, 1955; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; interned and family practice residency University of South Alabama, Mobile, AL, 1984-87; elected by South Mississippi Medical Society.

Trotter, Robert E., Columbus. Born Grenada, MS, May 1, 1944; MD, University of Mississippi School of Medicine, Jackson, MS, 1970; interned one year Keesler AFB, Biloxi, MS; general surgery and ob-gyn residencies, State University of New York at Buffalo, School of Medicine, Buffalo, NY, 1973-78; elected by Prairie Medical Society.

Walton, Billy R., Tupelo. Born Attala County, April 12, 1961; DO, West Virginia School of Osteopathic Medicine 1988; interned Community General Hospital, Harrisburg, PA, one year; family practice residency, University Medical Center, Jackson, MS, 1989-91; elected by Northeast Mississippi Medical Society.

Deaths

Ford, John M., Baldwyn. Born Baldwyn, MS June 28, 1923; MD, Tulane University School of Medicine, New Orleans, LA, 1947; interned one year Charity Hospital, Shreveport, LA; died November 27, 1991, age 68.




WE'RE ALWAYS
ON CALL.
1-800-352-2226
Call the travel specialists toll-free!
When you come down with the urge or necessity to travel, call Avanti for expert service. Everything we do for you is free of charge, even the phone call.
Our travel specialists will take care of all your plans, plane reservations, car rental, hotel accommodations and much more. We're here to help you with charters, tours, cruises, personal vacations, business meetings and conventions.
The next time you make travel arrangements, remember Avanti is always on call, toll-free.
AVANTI
TRAVEL, INC.
Three Lakeland Circle • Jackson, Mississippi 39216 • 981-9111
Call Toll-Free Nationwide 1-800-327-4236

Personals

William Travis Avara, III, of Moss Point was recently initiated as a Fellow in the American College of Surgeons.

C. Ron Cannon, of Jackson has been appointed by The American Academy of Otolaryngology - Head and Neck Surgery to the Academy's Long Range Planning and Development Committee for a three year term.

Edward L. Carruth announces the opening of Immediate Care Clinic, Family Practice, 1710 14th Street, Meridian, MS.

Edgar Draper, professor and chairman of psychiatry and human behavior at UMC, has attained Life Fellow Status in the American Psychiatric Association.

Robert R. Herrington, III, a family practice physician at Columbia Family Clinic, was recently re-elected as a director of the Mississippi Academy of Family Physicians for district I.

James Gordon a urologist from Tupelo just returned from teaching the TULIP procedure at the University of Tokyo and Yamato Hospital in Tokyo.

Patrick Hsu announces the relocation of his office to Doctor's Plaza, Suite 110, Alcorn Drive, Corinth, MS.

Peter Kamp, of Hattiesburg has been certified by the American Board of Psychiatry and Neurology.

Bruce M. Kuehnle, of Natchez has associated with the Tillman Medical Group as Senior Consultant in surgery.

Paul G. Matherne of Biloxi has been appointed medical director of the Wound Care/ Hyperbaric Medicine Department at Gulf Coast Memorial Center in Biloxi.

Luis Felipe Mosquera of Yazoo City, has been re-certified as a Diplomat of the American Board of General Surgery.

Martin M. Newcomb of Jackson has associated with The Street Clinic, Vicksburg as Consulting Oncologist.

A. N. Nichols announces the relocation of his office to 414B Marion Drive, McComb, MS.

Physicians' Recognition Award

Five MSMA members were named recipients of the AMA Physicians' Recognition Award in November 1991. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These five individuals are presented below by medical society.

Coast Counties
Michael John Gandour, MD

East Mississippi
Diego Velasco, MD

South Mississippi
Thomas Henry Blake, MD
Cleveland Eric Johnson, MD

Singing River
John J. McCloskey, MD

Mathew Page of Greenville was elected vice-president of the State Board of Medical Licensure on November 21, 1991.

T. Steve Parvin of Starkville was elected secretary of the State Board of Medical Licensure on November 21. 1991.

W. J. Patterson a Clinton family practice physician was recently named Methodist Medical Center's new chief of staff for 1992.

Walter Rose of Indianola was elected president of the State Board of Medical Licensure on November 21, 1991.

Buddy Savoie of Jackson as a speaker at the Rheumatoid Symposium in November in Jackson and also spoke in Cincinnati, Ohio at a wrist seminar of the subject of carpal instability. In December he taught a course on Shoulder Instability and Rotator Cuff Problems in Mulheim, Germany.

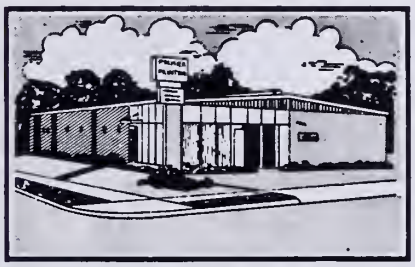
Eddie C. Starnes, a gastroenterologist has joined Rush Medical Group, PA of Meridian.

Louis F. Wilkins, of Brookhaven announces his retirement for the practice of medicine and surgery as of February 1, 1992. ❑

Items for the *Personals Column* may be sent to the Editor, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229

PRINTING — OFFICE SUPPLIES

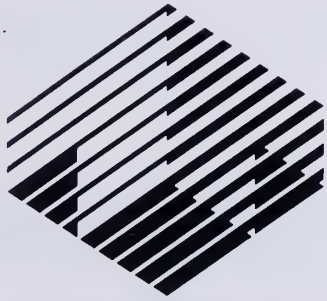
EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091



We earn your trust every day.™

Trustmark National Bank

Jackson/Bogue Chitto/Brandon/Brookhaven/Canton/Clinton/Columbia Florence/Flowood/Georgetown/Gloster/Greenville/Greenwood/Hattiesburg Hazlehurst/Hernando/Horn Lake/Leland/Liberty/Madison/Magee/McComb Olive Branch/Pearl/Pelahatchie/Petal/Richland/Ridgeland/Southaven Tylertown/Wesson

Member FDIC

MSMA-SPONSORED
Standard Insurance Claims Forms
HCFA 1500

☐ • **Old two-part snap-out, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part snap-out, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$37.25 Plus State Sales Tax**	**$45.00 Plus State Sales Tax**

☐ • **Old two-part continuous, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part continuous, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$39.00 Plus State Sales Tax**	**$47.00 Plus State Sales Tax**

- **All orders plus 6% Mississippi Sales Tax unless your organization is tax exempt**
- **Price includes all delivery and handling costs**
- **Rapid Shipment via UPS**

ORDER INFORMATION

RETURN ORDER BLANK TO:

Order Department - Insurance Forms
Mississippi State Medical Association
PO Box 5229
Jackson, MS 39296-5229

Call in orders:

(Toll Free In-State Wats)	1-800-898-0251
Jackson and surrounding area	354-5433
MSMA Fax Number	352-4834

SHIP ORDER TO:

_____
_____
_____
_____
(Please indicate street address and zip code)

_____
(name of individual placing order)

_____
(purchase order #)

_____
(phone #)

Placement Service
Physicians Wanted

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

Pascagoula Mississippi - Anesthesiologist Position Available for BC/BE Anesthesiologist. We administer all types of anesthesia including: open heart, cardiovascular, obstetrics, and general. Current compensation package competitive nationwide. Fringe Benefits include health, dental, life, long-term disablity, and malpractice insurance. Also included continuing education allowances, holidays and vacations. Local climate offers year-round recreation opportunities outdoors. Progressive city on Gulf, home to US Navy, many manufacturing facilities along with local seafood industries. Excellent school systems including division of University of Southern MS. Send CV to Pascagoula Anesthesia, Ltd. P.O. Box 1684, Pascagoula, MS 39568, (601)769-1021.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

Family Practice/ ER Physician needed for fill-in coverage for CME, vacation, and Saturdays, 9:00 am to 6:00 pm. North East Jackson. Call 957-2273.

Exceptional Internal Medicine Opportunity. Member of 10-physician IM Multispecialty group. 1 in 4 coverage. Enjoy a most desirable community as well as a very progressive medical clinic. Excellent compensations and benefits. Paid interviewing and relocation expenses. Send CV to Linda Crowson, Meridian Medical Associates, P.A., 2nd Floor, 2024 15th Street, Meridian, MS 39301.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.



Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Emergency Medicine Opportunities -- Spectrum Emergency Care, the nation's largest provider of emergency department staffing and management services, currently has full and part-time staff physician opportunities at select client hospitals in Mississippi. As an independent contract physician, you will enjoy a variety of geographical locations in both large and small hospitals. Spectrum also offers participation in an occurrence-based malpractice insurance program, flexible scheduling, administrative support, and the opportunity for advancement. To learn more about the exciting opportunities currently available, **call Dan Fuller at 800/325-3982, ext. 7809.** Spectrum Emergency Care, 999 Executive Parkway, St. Louis, MO 63141.

Vacation/Temporary Coverage: BC/Anesthesiologist and CRNA desire to work locums. Call 1-800-241-7828

Ophthalmologist Wanted for thriving, state-of-the-art eye practice in Columbus, Mississippi, seeking to add an associate leading to a partnership. Beautiful city of 25,000 with many varied recreational, social, and cultural activities. Competitive package. **Contact Albert Laws, M.D. at (601) 328-1254 or 2475 North 5th Street, Columbus, MD 39701.**

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

ARKANSAS DEPARTMENT OF CORRECTIONS

Primary Care Physicians needed for the Multi-site Arkansas State Prison System. Since 1987, PHP Healthcare has been providing comprehensive medical services for this complex of 13 Clinics and a 24 Bed Diagnostic Hospital.

PHP HEALTHCARE OFFERS:

- Competitive Compensation
- Flexible schedule to meet your needs
- Malpractice insurance
- Full-time and Part-time Hours Available

FOR FURTHER INFORMATION CONTACT:
Leigh Robbins
PHP Healthcare Corporation
7044 Northridge Drive
Nashville, TN 37221
615/662-1310

EMERGENCY ROOM AND AMBULATORY CARE PHYSICIANS

PHP HEALTHCARE CORPORATION, a leader in healthcare management services, has an immediate need for physicians to staff an **emergency room & ambulatory care clinic** in Millington, Tennessee (Memphis Area).

Emergency Department Qualifications Include:

- BE/BC in Emergency Medicine
- ATLS
- Current State Licensure

Ambulatory Care Clinic Qualifications Include:

- ACLS
- Current State Licensure

PHP PROVIDES PAID MALPRACTICE INSURANCE AND EXCELLENT COMPENSATION.

For further information please call or send your CV to:
Leigh Robbins
PHP Healthcare Corporation
7044 Northridge Drive
Nashville, TN 37221
(615) 662-1310

EOE, m/fPHP provides paid malpractice insurance and excellent compensation. If interested please call or send CV to:

PHP Healthcare Corporation
7044 Northridge Drive
Nashville, TN 37221
Attn. Leigh Robbins
(615) 662-1310

SOUTHERN INDEPENDENCE

Large practice, small town. Established Family Medicine group in pre-revolutionary Pee Dee area community seeking physicians for a life-time commitment. New building, equipment, facilities, unequaled elsewhere. A truly special career opportunity in Family Medicine for a special physician. It don't get no better - friendly town with excellent quality of life. BC/BE only, please. $100,000+. Want more info? Contact:

Cheraw Family Medicine
Attention: C. Radkin
PO Box 867
Cheraw, South Carolina 29520
(803) 537-2171. Call collect.

Losing money to Medicaid/Early Periodic Screening Diagnostic Testing claim errors? Prevent needless denials with our specialty program. Easy to understand and use. Exceptional quality at an affordable price. Call or write for details today. MicroMax Software, P.O. Box 1215, Starkville, MS 39759, (601) 324-0079.

Classified

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

For Sale or Lease - Attractive office building 4200 sq. ft., 955 North State Street, Jackson, MS. One Block from Baptist Medical Center. Call (601) 948-1707.

For Sale or Lease - Attractive office building in Jackson, on Highway 18 near Methodist Medical Center (formerly Hinds General Hospital). **8,000 sq. ft. available in suites and individual offices; newly carpeted and painted.** Ideal for Doctors or Medical Clinic. **Call 366-2478 or 354-3000.**

FOR SALE: 3,000 sq. ft. -- DOCTORS OFFICE BUILDING -- 2,200 sq. ft. designed for Internists and 800 sq. ft. for Dental Office. Excellent condition, close to Methodist Hospital, shopping centers, 9 schools. **Helen Greenberg, Realtor, Inc. #353-9394.**

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

Index to Advertisers

Avanti 73

CancerPay Plus 44

Disability Determination 78
Doctors Insurance Reciprocal 56

Eli Lilly & Co. ..... 58 & 59
Employers Insurance, Inc. 48
Employer Plus, Inc. 69

Harreld Chevrolet-Oldsmobile 72

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 48
MS Emergency Association 77
MS Methodist Rehabilitation Center ..... **second cover**
MS Physicians Insurance Company **6**
MS State Department of Health 49
MSMA Benefit Plan & Trust **4**
MSMA Sponsored Insurance Plan 68

Physician Services of America 59
Premier Printing 75

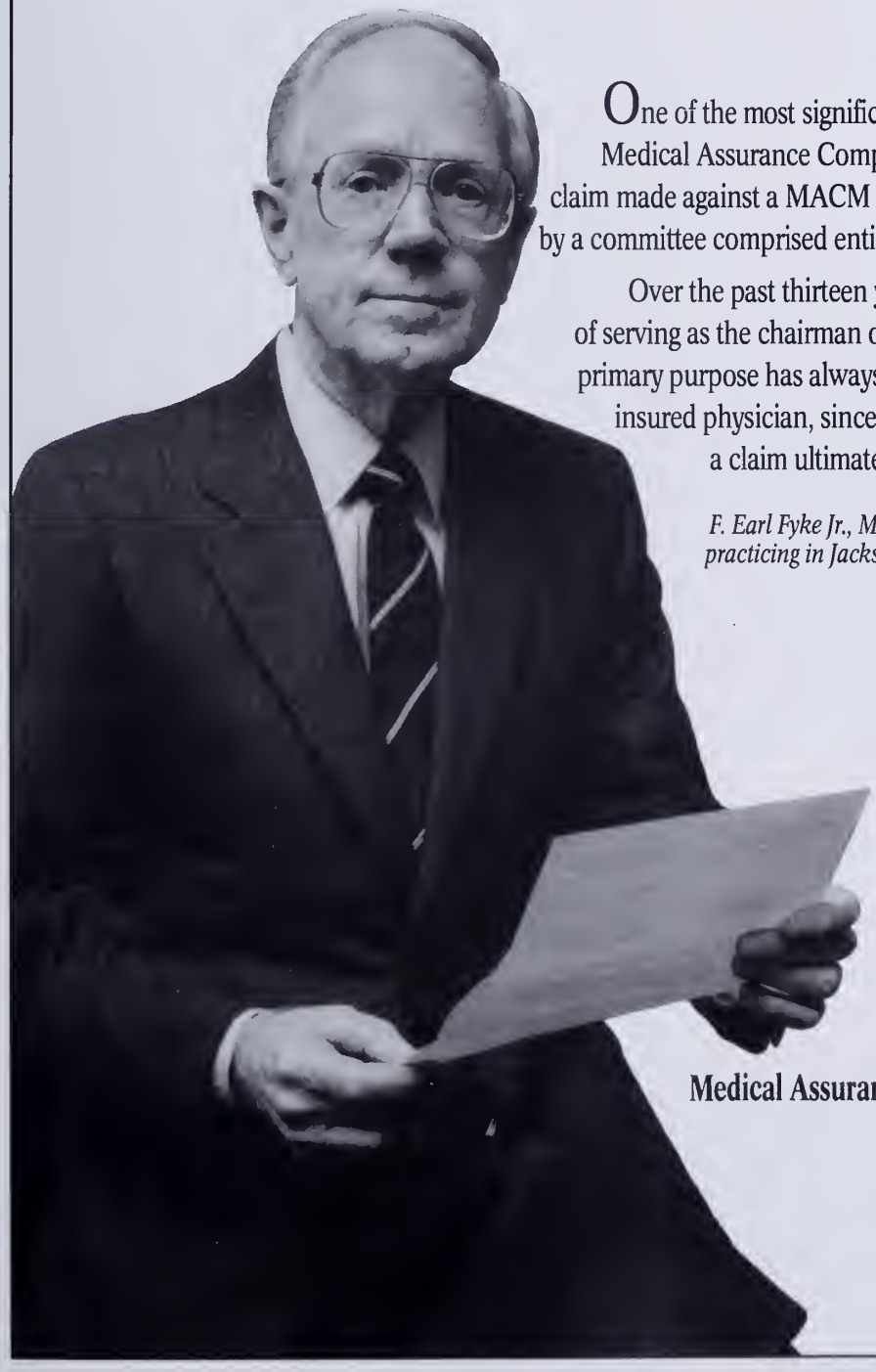
Searle ..... **fourth cover**

The Doctors' Company 70
Trustmark 75

US Air Force 51
US Air Force Reserve 59
US Army Reserve 43

Jon Wimbish **8**

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

ONCE DAILY 180mg Calan® SR
verapamil HCl 180 mg
SUSTAINED-RELEASE CAPLETS

LIBRARY

FEB 2 1 199

N.Y. Academy of Me

The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE *G.D. Searle & Co.*
Box 5110, Chicago, IL 60680

A91CA6148T



JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MARCH 1992





Bitter. Mad. Hateful. Disappointed. You never know what a day might bring.



That friendly man who answers the phone at MMRC doesn't sound like the same one who showed up 16 years ago at our front door.

A tragic car wreck had left Lamar Myers a quadriplegic. And had left him some pretty bitter feelings to try and deal with.

Fortunately, he wasn't left to deal with them alone. Because the staff at MMRC showed him that life goes on.

"Everybody was willing to work with me," he says. "All I had to do was try. My life didn't have to end the night of that car wreck."

Through months of physical, occupational and recreational therapy, Lamar gained a whole new respect for life. And the staff at MMRC never stopped caring.

It's that commitment to rebuilding patients' lives that makes MMRC the South's leading rehabilitation center. If you don't believe it, just give our switchboard a call.

You'll hear a lot more than a simple "hello" on the other end of the line. You'll hear the voice of a friend who never said goodbye.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MARCH 1992 VOLUME XXXIII NUMBER 3

SCIENTIFIC ARTICLES

Treatment of Unruptured Ectopic Pregnancy with Methotrexate 81

John Isaacs, MD; G. Rodney Meeks, MD; Harriette L. Hampton, MD; Michel E. Rivlin, MD; Ramon P. McGehee, MD; Cecil A. Long, MD and Bryan D. Cowan, MD

A Cholesterol Reduction Demonstration Project: Results from a Challenge Between Two Cities 87

Joshua E. Muscat, MPH; Randall E. Harris, PhD, MD; Nancy J. Haley, PhD and Ernest L. Wynder, MD

EDITORIALS

A Prescription For The Physician 96

James C. Waites, MD

Ethics and Economics 97

George Abraham, MD

The Best Medicine Sometimes Can't Be Bought 97

Joseph E. Johnston, MD

DEPARTMENTS

Current Opinions 101

Medical Organization 104

New Members 113

Deaths 113

Personals 115

Placement Service 119

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

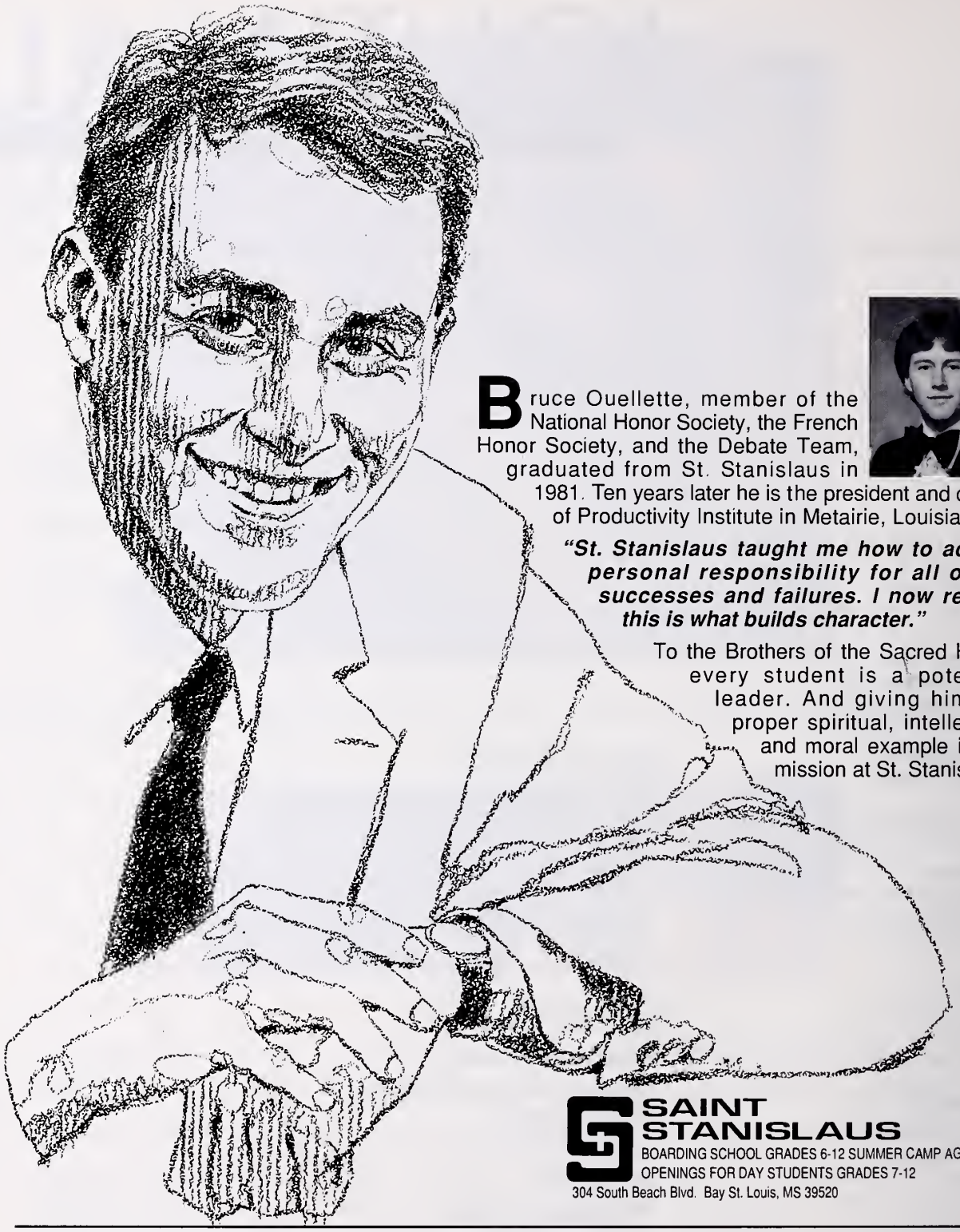
PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
James C. Waites, MD
President
William C. Gates, MD
President-Elect
Don Q. Mitchell, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.



Bruce Ouellette, member of the National Honor Society, the French Honor Society, and the Debate Team, graduated from St. Stanislaus in 1981. Ten years later he is the president and owner of Productivity Institute in Metairie, Louisiana.

"St. Stanislaus taught me how to accept personal responsibility for all of my successes and failures. I now realize this is what builds character."

To the Brothers of the Sacred Heart, every student is a potential leader. And giving him the proper spiritual, intellectual and moral example is our mission at St. Stanislaus.

SAINT STANISLAUS

BOARDING SCHOOL GRADES 6-12 SUMMER CAMP AGES 9-14
OPENINGS FOR DAY STUDENTS GRADES 7-12
304 South Beach Blvd. Bay St. Louis, MS 39520

FOR A FREE BROCHURE CALL THE DIRECTOR OF ADMISSIONS — (601) 467-9057

St. Stanislaus helps build leaders.

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 3

March 1992

Dear Doctor:

The **MSMA 124th Annual Session will be held April 29 - May 3, 1992, at the Ramada Renaissance Hotel, Jackson, MS.** A schedule of meetings and other activities is printed on pages 110 - 111 of this issue of the *Journal MSMA*.

On Thursday afternoon, April 30, the MSMA Young Physician's Section and the MSMA Hospital Medical Staff Section are hosting a panel dicussion on **Parameters of Care. This session is open to all annual session participants**. The panel's speakers will include: representatives from the Office of Quality Assurance and Assessment, American Medical Association and the Agency for Health Care Policy and Research, Department of Health and Human Services. A third panelist, representing a national speciality society, will discuss coordinating the development of practice parameters.

The **Scientific Assembly Medicine Plenary Session** will be held Friday, May 1, from 8:00 am to noon. The **Surgery Plenary Session** will be held Saturday, May 2, from 8:00 am to noon. **CME credit will be designated for both the Medicine and the Surgery Plenary Sessions.**

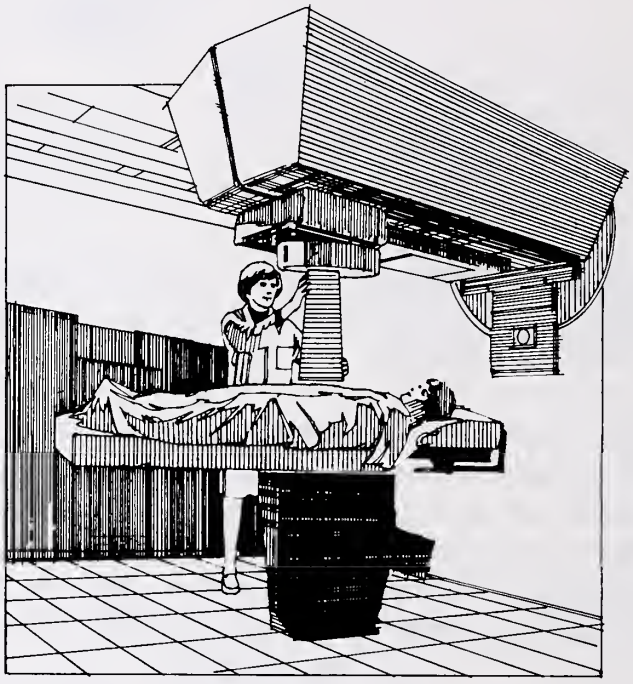
The opening session of the **MSMA House of Delegates will convene, Thursday, April 30, at 9:00 am** in Ballroom A at the Renaissance. **MSMA Reference Committee A** will also be held on Thursday, April 30, at 4:00 pm in Ballroom A.

On Friday, May 1, **MSMA Reference Committee on Constitution and Bylaws** will be held at 1:00 pm in Seminar Rooms I & II. **MSMA Reference Committee B** will be held at 2:00 pm immediately following Constitution and Bylaws in Seminar Rooms I & II. The concluding session of the **MSMA House of Delegates will convene, Sunday, May 3, at 9:00 am** in Ballroom A.

The MSMA President's Reception will be held on Thursday evening, April 30, at the Jackson Zoological Park beginning at 6:00 pm. The Annual MSMA/MSMA Auxiliary Membership Party will be held Saturday evening, May 2, beginning at 6:30 pm in the Grand Ballroom of the Ramada Renaissance.

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 3

State to pay $82M more for Medicaid

Jackson, MS - Funding Medicaid next year will cost $82 million more than legislators had projected, according to Medicaid Director Helen Wetherbee. Rising health-care costs, a growing patients pool and new federal mandates make the hike necessary, Wetherbee told the House Appropriations Committee.

Wetherbee said lawmakers could either trim some Medicaid services or tax providers to generate revenues. "It's terribly painful for all states, but it's particularly hard in Mississippi because we have the highest percentage of the population on Medicaid," Wetherbee said of the 500,000 Mississippians participating in Medicaid.

The Joint Legislative Budget Committee recommended last fall a $175 million Medicaid appropriation for fiscal year 1993, which begins July 1, 1992. That represents a 9 percent increase over the 1992 appropriation. Within the additional $82 million, the state's portion of the Medicaid budget would jump 61 percent next year. The federal government puts $4 into the Medicaid program for every $1 Mississippi spends.

Medicaid's current budget is $1.1 billion and its proposed budget for 1993 is $1.3 billion. Rep. Charlie Capps of Cleveland, Appropriations Committee chairman, said finding the extra money will be difficult. "We cannot continue to have business as usual in your department," Capps told Wetherbee. "We've got to do something."

Wetherbee said lawmakers could: (1) Eliminate some of the 12 optional Medicaid services. For example, the state could stop paying for glasses for adult Medicaid patients. (2) Assess a tax on all doctors, hospitals, nursing homes and other health-care providers. Mississippi currently taxes doctors, hospitals, nursing homes and other health-care providers that take Medicaid patients. Federal law now requires that any such tax must be levied on all providers - not just the Medicaid providers.

Office of Disabilities Prevention Formed

Jackson, MS - Tom Mitchell thinks everybody should wear a seat belt. And Mitchell should know. Mitchell, 37, wasn't wearing his seat belt when he hit a rough patch at Northside Drive and Flag Chapel Road in Jackson on April 21, 1981. He lost control of the 1975 Thunderbird he was driving and as a result he is now paralyzed from the chest down. He said a seat belt could have spared him.

Mississippi very possible leads the country in the percentage of people with preventable disabilities, state rehabilitation officials say. But thanks to a $1 million grant from the Centers for Disease Control in Atlanta, the state Department of Rehabilitation Services hopes to free the state of that dubious distinction.

In Mississippi we do not have the means to meet all the need of our people," said Christine Gilliland, project director for the newly formed Office of Disabilities Prevention. Gilliland estimated that about 13.7 percent of the state's population, or more than 353,000 people, have a disability. The Office of Disabilities which will work hand in hand with the state Department of Health, also hopes to identify certain "at-risk" categories of people and educate them on what to do to avoid injury. "We plan on developing community programs to draw attention to the need for prevention," Gilliland said. "Even the most ignorant and uneducated person can be made to understand what they're doing to their unborn child if they're smoking, drinking and taking drugs."



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

Treatment of Unruptured Ectopic Pregnancy With Methotrexate

JOHN ISAACS, MD
G. RODNEY MEEKS, MD
HARRIETTE L. HAMPTON, MD
MICHEL E. RIVLIN, MD
RAMON P. MCGEHEE, MD
CECIL A. LONG, MD
BRYAN D. COWAN, MD

The incidence of ectopic pregnancy has increased dramatically during the past two decades. Currently, nearly 20 ectopic pregnancies develop per 1000 live births in the United States. Approximately 70,000 tubal pregnancies result in 35-40 maternal deaths each year.[1] Reasons for the rising incidence of ectopic pregnancy are not completely understood. Important factors which may influence this trend include improvements in diagnostic tests that detect the condition, better reporting methods, and acquired risks for ectopic pregnancy (see Table 1).[2] With early detection, tubal pregnancy can now be treated before symptoms and tubal rupture occur. Most commonly, ectopic pregnancy is treated with surgery. Recently, non-surgical treatments have become possible. This article reviews the concepts of early diagnosis and medical (non-surgical) management of unruptured tubal pregnancy.

Table 1- Risk Factors for Ectopic Pregnancy

Pelvic inflammatory disease
Pelvic surgery
Tubal ligation
Previous ectopic pregnancy
Endometriosis
Gamete technologies
Advanced maternal age

DIAGNOSIS

Patients with ectopic pregnancy are encountered in two different clinical settings. Women with symptoms of ectopic pregnancy are usually seen in the emergency room. Symptoms of tubal pregnancy are abdominal pain (95%), vaginal bleeding (60%), or a palpable adnexal mass (35%).[3] These findings, however, are often present in women with other diagnoses. Asymptomatic patients present earlier in the course of their disease through their obstetrician or during an infertility investigation. The latter group provides the greatest opportunity for early diagnosis and conservative intervention. In the past patients with tubal rupture accounted for 85% of all cases of ectopic pregnancy. This was especially true when diagnosis was based on the classic triad of pelvis pain, abnormal vaginal bleeding, and an adnexal mass. Unfortunately, this triad occurs in only one-third of patients with ectopic pregnancy.

Improvements in diagnostic measures for early detection of ectopic pregnancy have greatly influenced the morbidity and mortality of affected patients. Human chorionic gonadotropin (hCG) measurements and high resolution pelvic sonography have been employed to detect ectopic pregnancies early during the course of the condition. With these detection methods, a substantial proportion of ectopic pregnancies are diagnosed prior to the onset of symptoms or tubal rup-

ture.

Human chorionic gonadotropin concentrations can be highly predictive of both gestational normalcy and gestational abnormalities. During the first 40 days of pregnancy, the hCG titer doubles approximately every two days. A single quantitative serum hCG determination has limited value in predicting gestational normalcy. The quantitation of hCG has been complicated by the existence of two reference standards for hCG (Second International Standard [Second IS] and the International Reference Preparation [IRP]).[4] It is important to know which hCG reference is used when correlating hCG levels with clinical interpretation and other diagnostic modalities. For estimates of conversion, 1 mg of hCG is approximately equal to 5 mIU of the Second IS and 9.2 mIU of the IRP. Approximately 88% of patients with a normal hCG doubling will have a normal intrauterine pregnancy and ultimately deliver. Approximately 75% of patients with abnormally slow hCG doubling will have an intrauterine abortion of ectopic pregnancy. Human chorionic gonadotropin determinations cannot discriminate between an ectopic pregnancy and an intrauterine abortion.

The formula to calculate hCG doubling time is:

$$DT\ days = \frac{\log_{10}(2)(Interval_2 - Interval_1)}{\log_{10}(hCG_2/hCG_1)}$$

The calculation of hCG doubling times is clumsy. For clinical purposes, it is more appropriate to simply estimate increments. The minimum expected increment is of the greater interest rather than the average increment. As a rule of thumb, the following serves as a guideline:

Sampling Interval (days)	Minimum Expected Increase in hCG
2	66%
3	100%

In addition to hCG monitoring, ultrasonography allows the clinician to visualize the site of the gestation. A positive sonographic diagnosis can be made by identifying an extrauterine fetus. A presumptive diagnosis of ectopic pregnancy can be made by failure to visualize an intrauterine gestation when the hCG titer is above the "discriminatory hCG zone." The discriminatory hCG zone is defined as the range of hCG concentrations above which a normal intrauterine gestation will be visualized, and below which an intrauterine gestational sac is usually not visible. The absence of an intrauterine gestational sac when the hCG concentration exceeds the discriminatory level is diagnostic of ectopic pregnancy in 85% of cases. Transvaginal sonography allows higher resolution than transabdominal sonography. As a result, gestational sacs can be visualized when the hCG level reaches approximately 2000 mIU/mL (IRP) or 1000 mIU (Second IS). Transabdominal sonography requires a discriminatory hCG titer $\geq$ 6000 mIU/mL. The use of transvaginal imaging effectively lowers the discriminatory zone and allows earlier identification of abnormal gestations. Because there is variability among hCG assays and the resolution of different imaging systems, each laboratory and clinical service must establish its own discriminatory zones for both transabdominal and transvaginal sonography.

As an additional potential diagnostic test, progesterone monitoring in abnormal pregnancies has been investigated.[5] Progesterone production is decrease in ectopic pregnancies compared to intrauterine gestations of the same gestational age. Data at our institution indicated that the best discriminatory progesterone is 10 ng/mL. If the progesterone concentration is < 10 ng/mL, 90% of these pregnancies will be abnormal. However, unlike hCG doubling times, progesterone concentrations are unable to predict normalcy.

SURGICAL MANAGEMENT

In deciding the best management for each patient, age, reproductive history, and desire for future reproduction must be considered. For most patients the goal of treatment is to remove the ectopic pregnancy and preserve reproductive function. However, in the face of tubal rupture, significant anatomic distortion, or overt hemorrhage, nonconservative removal of the tube and pregnancy may be advisable. Ipsilateral salpingo-oophorectomy is not recommended unless the ovary is compromised or abnormal. The patient with a previous sterilization who has an ectopic pregnancy should have the tube and ectopic pregnancy excised. Curiously, 75% of pregnancies occurring after failure of tubal sterilization are ectopic.

Conservative surgery is most appropriate when an infertile woman has an unruptured ectopic pregnancy and wishes to preserve her reproductive potential.[6] Ampullary salpingostomy is the most common conservative tubal operation and is frequently performed by laparoscopy. A linear incision is made with electrocautery, laser, or sharp incisions over the antimesenteric portion of the tube. The products of conception

and blood clot are removed with forceps or by gentle evacuation. Prior to linear salpingostomy, dilute vasopressin may be injected into the mesosalpinx below the conceptus or into the tubal wall. Vasopressin (20 units) should be diluted with 10-20 cc of normal saline prior to injection.

Isthmic ectopic pregnancies are usually not amenable to linear salpingostomy. Resection of the involved segment of tube and ectopic pregnancy is the best surgical approach. Excision has the advantage of removing a presumably abnormal region of the tube while preserving the proximal and distal segments for future tubal anastomosis.

Persistence of viable trophoblast tissue occurs in 5% of patients who undergo conservative surgical treatment. The etiology of this condition is unknown. It is believed that trophoblast cells are incompletely removed and continue to proliferate. To monitor for this complication, patients should undergo weekly serum hCG testing until nonpregnant levels are achieved.

MEDICAL THERAPY

Medical treatment of unruptured ectopic pregnancy is an attractive alternative because it avoids a surgery, preserves reproductive potential, and reduces the cost of medical care.[7] In addition to primary therapy for unruptured tubal pregnancy, medical treatment has been advocated for persistent trophoblast after conservative tubal surgery and cervical pregnancy.

Methotrexate (MTX, a folinic acid antagonist) was the first drug used as a medical treatment for ectopic pregnancy. Dosage and treatment schedules using MTX are empiric and have been modeled after experience in gynecologic oncology in the treatment of gestational trophoblastic neoplasms. The usual route of administration is intramuscular injection. Potential adverse effects of MTX therapy include stomatitis, gastritis, enteritis, transient alopecia, leukopenia, bone marrow suppression and transient elevation of liver enzymes (see Table 2). Oral MTX and direct injection of MTX into the pregnancy have also resulted in cures. Direct injection of MTX has the potential advantage of reducing systemic toxicity from MTX by decreasing the amount of drug used.

Candidates for MTX treatment should meet certain criteria (see Table 3). The diagnosis of suspected ectopic pregnancy requires an abnormally slow hCG increase and vaginal sonographic confirmation of an empty uterus when the hCG is > 2000 mIU/mL (IRP). Patients with impending tubal rupture or a contraindication to MTX should be excluded (see Table 4). Pretreatment evaluation should consist of a complete blood count, platelet count, liver function tests, hCG quantitation, and a vaginal sonogram (see Table 5).

Methotrexate is generally administered as an IM injection of 1 mg per kg of body weight on days 1, 3, and 5 of treatment. Leucovorum rescue (optional) is employed at 0.1 mg of leucovorum per kg of body weight on day 2, 4 and 6 of treatment to reduce systemic drug toxicity (see Table 6). Treatment efficacy is followed by weekly hCG measurements until val-

Table 2 - Adverse Effects of Methotrexate

Stomatitis
Gastritis
Enteritis
Transient Alopecia
Leukopenia
Bone Marrow Suppression
Transient Elevated Liver Enzymes

Table 3 - Selection Criteria for Methotrexate Treatment of Ectopic Pregnancy

Ectopic pregnancy < 3 cm
Desire for future fertility
Peak hCG < 15,000 mIU/mL (IRP)
No active bleeding
Selected cases of cornual or cervical pregnancy
Persistent ectopic pregnancy
Suspected ectopic pregnancy

Table 4 - Contraindications to Methotrexate Therapy for Ectopic Pregnancy

Impending tubal rupture
Poor patient compliance
Active hepatic or renal disease
Fetal cardiac activity
Active peptic ulcer disease
Thrombocytopenia or leukopenia

Table 5 - Evaluation of Women with Unruptured Ectopic Pregnancy Prior to Treatment with Methotrexate

Hemoglobin/Hematocrit
White Blood Cell Count
Platelet Count
Liver Function Tests
hCG Quantitation
Vaginal Sonogram

Table 6 - The UMC Protocol for Methotrexate Treatment of Unruptured Ectopic Pregnancy

Methotrexate 1 mg/kg [not to exceed 100 mg] intramuscularly on days 1, 3, and 5.
Leucovorum 0.1 mg/kg on days 2, 4, and 6.
Weekly hCG measurements.

ues achieve nonpregnant concentrations.

More than 200 cases of ectopic pregnancy treated with methotrexate have been reported in the English literature. Over 90% of these have been cured without the need for surgery. The remainder required surgery because of pain, rupture, or persistent hCG titers. Although follow-up of these patients is relatively short, approximately 80% of studies patients maintained tubal patency of the affected tube, and nearly 40% of these women have conceived again. The incidence of repeat ectopic pregnancy is about 10%. Although the number of women treated with methotrexate is small compared to the larger population of women treated with surgery, tubal patency, subsequent pregnancy, and repeat ectopic pregnancy occurs in nearly equal frequency in both groups.

UMC EXPERIENCE

Nine patients with tubal pregnancies have been treated with methotrexate at the University of Mississippi Medical Center (see Table 7). Five of these patients chose medical therapy to avoid surgery and preserve reproductive capacity, and four had rising hCG titers after conservative surgical treatment of their ectopic pregnancies (persistent trophoblast). Duration of follow-up among these women has ranged from 13 to 60 months.

Eight patients were treated with intramuscular methotrexate (1 mg methotrexate/kg body weight on days 1, 3, and 5). All had resolution of their disease after a single course of therapy, and hCG titers were < 10% of the initial value after 21 days (see Figure 1). The only reported systemic side effects were stomatitis with diarrhea (mucositis) in one patient. These symptoms developed 8 days after initiating therapy. Stomatitis was treated with xylocaine oral rinse, and diarrhea was treated with loperamide. Her symptoms resolved 48 hours later. Subsequently three patients conceived. One pregnancy was a repeat ectopic pregnancy that was treated elsewhere. The other two resulted in term deliveries.

One patient was treated with transvaginal sonographic-guided amniotic sac aspiration with injection of 25 mg of methotrexate into the tubal pregnancy. This patient has an hCG titer of 14,229 mIU/mL (see Table 7), and transvaginal sonography demonstrated an extrauterine gestational sac in the right adnexa with car-

Table 7 - Nine UMC Patients with Unruptured Tubal Pregnancies Treated with Methotrexate

Initial	Condition	hCG Titer mIU/mL	Route	Pregnant Again	Complications
PE	Primary	1512	IM	Ectopic	Mucositis
PA	Primary	2360	IM	Term	None
AW	Primary	624	IM	No	None
JS	Primary	224	IM	No	None
CF	Persistent	142	IM	Term	None
ST	Persistent	5400	IM	No	None
MB	Persistent	4543	IM	No	None
DA	Persistent	17956	IM	No	None
BS	Primary	14229	SAC	Term	None

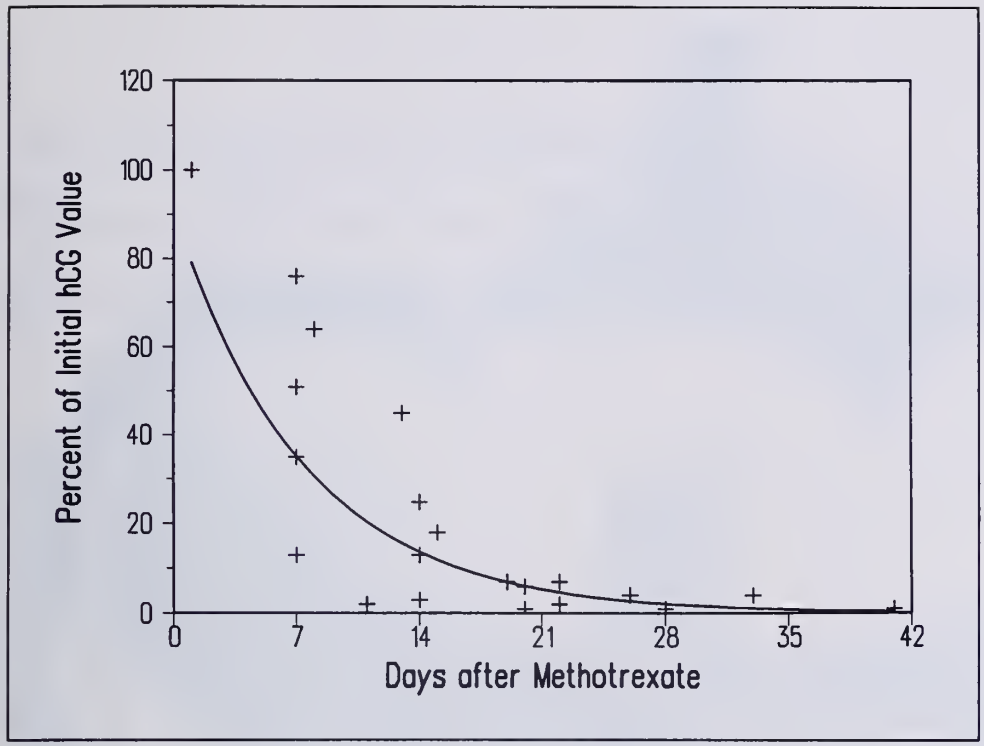


***Figure 1** - hCG decay curve of 8 women with ectopic pregnancies who were treated with intramuscular methotrexate. The data are graphed as a percent of the pretreatment hCG concentration against time. The power regression analysis resulted in the equation of $Y = 90.6e^{-0.14X}$ that had a correlation coefficient (r) of 0.869.*

dia activity. Injection was performed after intravenous sedation with local anesthesia (1% xylocaine). A 17-gauge needle with an echogenic tip was used under vaginal sonographic control to aspirate and then inject the tubal pregnancy. This patient has conceived a subsequent normal intrauterine gestation.

SUMMARY

Medical treatment is appropriate for patients with an unruptured tubal pregnancy who wish to preserve fertility or have medical problems associated with increased risk of anesthesia. Patients with persistent trophoblast after conservative surgery should be treated with methotrexate rather than undergo a repeat surgery. All nine of our patients with ectopic pregnancies who were treated with MTX were cured with one course of therapy. Little toxicity was observed and subsequent reproductive performance after medical treatment was comparable to that reported in the literature. Direct injection of MTX into an ectopic pregnancy under sonographic control provided an option for treatment which required little anesthesia, reduced the amount of drug and allowed the treatment of a gestation which would otherwise not be considered a candidate for the 3 dose intramuscular injection protocol (see Table 3). ❑

2500 North State Street
Jackson, Missisippi

Supported in Part by the Vicksburg Hospital Medical Foundation.

REFERENCES

1. Ectopic pregnancy - United States, 1986. MMWR 1989;38:481.
2. Leach RE, Ory SJ. Modern management of ectopic pregnancy. *J Reprod Med.* 1989;34:324.
3. Ectopic pregnancy. ACOG Technical Bulletin #150, December 1990.
4. Storring PL, Gaine-Des RE, Bangham DR. International reference preparation of human chorionic gonadotropin for immunoassay: Potency estimates in various bioassays and protein binding assay systems and international reference preparation of the alpha and beta subunits of human chorionic gonadotropin for immunoassay. *J Endocrinol* 1980;84:295.
5. Yeko T, Gorrill M, Hughes L, et al. Timely diagnosis or early ectopic pregnancy using a single blood progesterone measurement. *Fertil Steril* 1987;48:1048.
6. Pouly J, Mahnes H, Mage G, et al. Conservative laparoscopic treatment of 321 ectopic pregnancies. *Fertil Steril* 1986;46:1093.
7. Cannon L, Jesionowska H. Methotrexate treatment of tubal pregnancy. *Fertil Steril* 1990;55:1033.

From the Division of Reproductive Endocrinology, Department of Obstetrics and Gynecology, University of Mississippi Medical Center.



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

A Cholesterol Reduction Demonstration Project: Results from a Challenge Between Two Cities

JOSHUA E. MUSCAT, MPH
RANDALL E. HARRIS, PhD, MD
NANCY J. HALEY, PhD
ERNEST L. WYNDER, MD

A competition was conducted between Jackson, MS and Lansing, MI to reduce blood cholesterol levels among self-selected individuals who were generally at high risk for elevated coronary heart disease. Baseline plasma cholesterol levels were measured and risk factor data were recorded for 13,710 participants in Jackson and 6,719 in Lansing (6.8% and 5.1% of the total populations, respectively). A six month educational campaign was conducted in both cities which included nutritional seminars, television shows, newspaper advertisements etc. From Jackson, 6,244 participants returned for the follow-up screening, and 2,404 from Lansing (46% and 36%). Subjects who reported changes in their diets had an average cholesterol reduction of 19 mg/dl (9%) in Jackson, and 2 mg/dl (1%) in Lansing (after adjustment for sex, baseline level, and age, $P<0.01$). In Lansing, participants were less likely to have college degrees, and were more likely to have participated because of concern with previously determined elevated cholesterol levels than Jackson participants.

The National Cholesterol Education Program (NCEP) has issued guidelines to physicians for treating elevated blood cholesterol to reduce the risk of coronary heart disease.[1] The guidelines emphasis all adults should know their blood cholesterol level and how to control it. Community-based cholesterol screenings have detected elevated blood cholesterol in many individuals and large scale educational interventions have been effective in encouraging dietary changes to reduce cholesterol levels.[2] However, many Americans are unaware of their own levels, or do not take measures to reduce them.

With this in mind, we devised a demonstration project based on a competition to reduce elevated cholesterol levels in 2 communities; a competitive "Cholesterol Challenge" was initiated between the cities of Jackson, Mississippi and Lansing, Michigan. The objectives of this demonstration project were to educate the public on the risks of elevated blood cholesterol levels, encourage awareness of individual blood cholesterol levels, and motivate people to reduce and control their blood cholesterol through dietary changes, exercise, weight loss and other means.

MATERIALS AND METHODS

The mayors of several midwestern state capitals with moderately sized populations were approached to determine their interest in participating in competitive public health program. The cities of Lansing, Michi-

gan, and Jackson, Mississippi accepted the offer, and their populations were notified of an impending "Cholesterol Challenge" in February 1988. Each mayor issued public announcements on television, radio, and in the press, describing the nature of the competition and requesting the participation of community members. Plasma cholesterol levels were measured for self-selected participants at baseline cholesterol screenings. A six month media and education campaign was then conducted to describe dietary regimens and other treatments for reducing blood cholesterol. This campaign included newspaper articles, television news coverage, a supermarket nutrition flyer, a fat and cholesterol counter enclosed in select breakfast cereals, the "Cholesterol Challenger" newsletter, and diet and nutrition seminars. The extent of the media effort was determined by the participating cities. At the end of the intervention period, it was apparent that the Challenge was much more highly publicized in Jackson than Lansing. A follow-up screening was subsequently conducted in August, 1988, to determine the average reduction in plasma cholesterol in each city. A description of the chronological schedule of the project is shown in Figure 1.

Details of the baseline screenings were widely publicized in both cities. This effort involved physicians, hospital staffs, health and government officials, and media experts. A commercial television series in both Lansing and Jackson broadcasted the times and locations of the screening sites, and described the nature of cholesterol and its relation to coronary heart disease (CHD).

The baseline screenings were conducted over a nearly simultaneously four day period in each city following a one week promotion in the media. Each participant signed a consent form, paid $5 for a blood cholesterol level measurement and completed a computer scanable questionnaire. Information was collected on demographics, personal and family history of cardiovascular disease, the reason for participation, and cigarette smoking. All participants were offered the opportunity to have their levels rechecked

Figure 1

Schematic of Cholesterol Challenge

February, 1988	Mid-February	Education	August, 1988
Media annoucements describing basic protocol	Baseline Screenings	Media Announcements Nutritional Seminars	Six Month Follow-Up Screening
Lansing, Michigan			
Population: 130,414 80% White 20% Black	6,719 Screenees 95% White 4% Black 43% Males 57% Females	22 Nutritional Seminars 0 Worksites Newspapers [1] 462,000 Television [2] 705,000	2,404 Screenees 97% White 3% Black 42% Males 58% Female
Jackson, Mississippi			
Population: 202,895 52% White, 48% Black	13,710 Screenees 86% White 14% Black 38% Males 62% Females	122 Nutritional Seminars 8 Worksites Newspapers [1] 1,024,800 Television [2] 1,580,000	6,244 Screenees 88% White 12% Black 38% Male 62% Female

[1] Newspaper characters adjusted for circulation.

[2] Television impressions adjusted for Nielson Rating

Figure 1 - Schematic of Cholesterol Challenge

at the follow-up screening at no charge, and were tracked at the time of the initial screening by identification numbers affixed on the original questionnaire.

The biochemical methodology for American Health Foundation (AHF) cholesterol screenings has been discussed in detail.[3] Following the baseline screening, the Challenge was more highly publicized in Jackson than Lansing (see Figure 1). Five participating hospitals in Jackson independently offered free nutritional seminars to interested individuals. Approximately 122 nutritional seminars were held and regularly attended by over 1,000 Jackson residents throughout the intervention phase. Eight corporations officially "co-sponsored" the event by hosting some of the nutritional seminars. In Lansing, 500 participants attended 22 nutritional seminars which were held in 3 hospitals. There were no corporate sponsors in Lansing. Overall, the media campaign in Jackson had approximately twice the level of promotion as that in Lansing (see Figure 1).

At the follow-up screening, participants had their cholesterol levels remeasured and filled out a second questionnaire. Data was obtained on self-reported changes in diet, exercise, smoking cessation, physician prescribed changes in diet, smoking and medication, attendance at the nutritional seminars and their attitudes regarding the cholesterol challenge.

In Jackson, 6,244 participants (46%) returned for the follow-up screening and were successfully tracked from the baseline screening. In Lansing, there were 2,404 follow-up participants (36%) and 1,515 of these 2,404 follow-up participants (63%) were successfully tracked. Follow-up questionnaire data were lost on 889 participants. However, there were no differences in the follow-up cholesterol levels between those that were tracked and those who had missing data (215 $\pm$ 18 mg/dl versus 214 $\pm$ 20 mg/dl). The follow-up results on the available sample of 1,515 participants were therefore considered an adequate representation of all follow-up participants from Lansing.

The plasma cholesterol values used to define desirable, moderate, or high risk levels were taken from the guidelines of the National, Heart, Lung, and Blood Institute Consensus Conference.[4] Nutritional information and counselling was provided to all participants. Individuals with high plasma cholesterol levels or borderline levels with 2 or more other CHD risk factors were recommended to see their physician for retesting and lipoprotein evaluation. If a high risk person without a physician was identified, the participating hospitals provided names of physicians willing to accept new patients.

All analyses were conducted by comparing differences within each city. The means of age-specific plasma cholesterol levels and 95% confidence intervals were calculated by age decile. Using cholesterol values obtained from the follow-up screening, estimates of the mean reduction in cholesterol were obtained for categories of increasing baseline levels (<200, 200-239, 240-279, and >279 mg/dl) by sex and city. Analysis of covariance was performed for Challenge participants (those who returned for the follow-up screening) to determine the effects of interventions and changes in risk behavior on cholesterol reduction, by adjustment for age as a covariate. These behavioral changes were based on the follow-up questionnaire and included use of cholesterol lowering medications, dietary intervention, smoking cessation, and exercise regimens. Least squares estimates of means and effects and tests of statistical significance were obtained by the general linear models procedure of the Statistical Analysis System.[5]

RESULTS

A total of 13,710 persons were screened in Jackson (13,498 over age 17, or 9.4% of the total adult population) and 6,719 persons were screened in Lansing (6,580 over age 17, or 7.1% of the total adult population). As in previous community-based cholesterol screenings,[6-8] participants were predominately women, older, more highly educated, and more likely to be white than the general population. The two screened populations were similar in terms of age, marital status, reason for screening, and smoking characteristics (see Table 1). However, a greater percentage of participants in Jackson were female (62% vs. 57%), black (14% versus 3%) and college graduates (54% vs. 42% for men, and 36% vs. 29% for women).

The majority of participants reported health consciousness as the main reason for participating (56%). The low percentage of current cigarette smokers among men and women (15% and 14%) also reflects a high degree of health consciousness among the participants. A higher percentage of Lansing participants reported participating in the screening because of concern with previously determined elevated cholesterol levels (18% vs. 8% in Jackson).

Figures 2a and 2b show that mean and age-adjusted baseline plasma cholesterol levels for men were similar between the 2 cities. Similarly, levels were also comparable for women, whites and blacks between the 2 cities. For both Lansing and Jackson, Challenge participants (the subset of baseline partici-

Table 1. BASELINE DEMOGRAPHICS OF SCREENEES IN JACKSON, MISSISSIPPI AND LANSING, MICHIGAN.

CHARACTERISTICS	Jackson, Mississippi				Lansing, Michigan			
	Male		Female		Male		Female	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
SEX	5,271	38.4	8,439	61.6	2,904	43.2	3,815	56.8
AGE								
0 - 9	22	0.4	19	0.2	19	0.7	24	0.6
10 - 19	106	2.0	128	1.5	64	2.2	66	1.7
20 - 29	541	10.3	1,069	12.7	194	6.7	281	7.4
30 - 39	1,313	24.9	2,040	24.2	504	17.4	607	15.9
40 - 49	1,131	21.4	1,568	18.6	636	21.9	732	19.2
50 - 59	896	17.0	1,566	18.6	567	19.5	749	19.6
60 - 69	807	15.3	1,338	15.9	607	20.9	821	21.5
70 - 79	393	7.5	595	7.1	274	9.4	459	12.0
80+	66	1.3	121	1.4	40	1.4	75	2.0
RACE								
White	4,707	89.3	7,074	83.8	2,765	95.2	3,643	95.5
Black	540	10.2	1,339	15.9	71	2.4	103	2.7
Hispanic	2	0	6	0.1	32	1.1	34	0.9
Oriental	12	0.2	12	0.1	12	0.1	12	0.3
Other	10	0.2	8	0.1	24	0.8	23	0.6
MARITAL STATUS								
Single	631	12.0	1,054	12.5	349	12.1	519	13.7
Married	4,288	81.8	5,501	65.4	2,294	79.5	2,411	63.5
Separated	29	0.6	95	1.1	20	0.7	29	0.8
Divorced	231	4.4	859	10.2	165	5.7	345	9.1
Widowed	66	1.3	906	10.8	57	2.0	495	13.0
EDUCATION								
Grammar School	218	4.2	236	2.8	158	5.5	149	3.9
High School	906	17.3	2,356	27.9	762	26.4	1,398	36.8
Some College	1,326	25.3	2,825	33.5	752	26.0	1,167	30.7
College Graduate	1,718	32.7	2,006	23.8	671	23.2	639	16.8
Post Graduate	1,081	20.6	1,012	12.0	549	19.0	448	11.8
SMOKING								
Never Smoked	2,669	51.0	2,755	67.1	1,368	47.3	2,384	63.0
Ever Smoked	2,567	49.0	5,625	32.9	1,522	52.7	1,399	37.0
Current Smoker	789	15.0	1,156	13.7	412	14.2	499	13.1
REASON FOR SCREENING*								
Family History	507	9.6	1,130	13.4	264	9.1	540	14.2
High Cholesterol	419	7.9	750	8.9	454	15.6	742	19.4
Curiosity	1,520	28.8	2,381	28.2	890	30.6	983	25.8
Health Conscious	3,042	57.7	4,913	58.2	1,528	52.6	2,062	54.0

* includes multiple responses

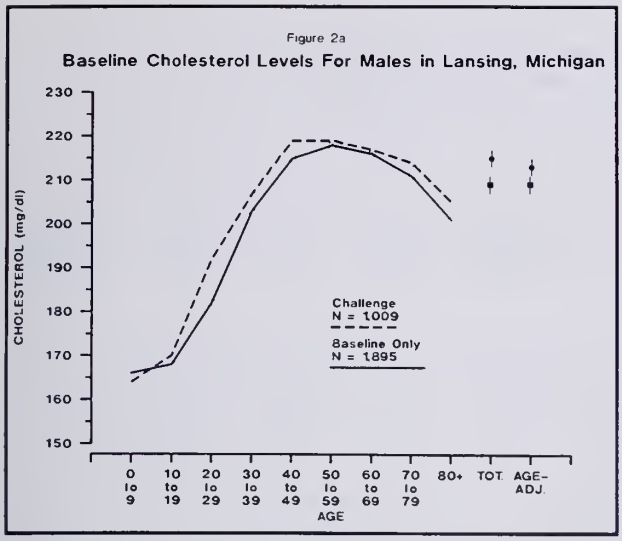


Figure 2a - Baseline Cholesterol Levels for Males in Lansing, MI.

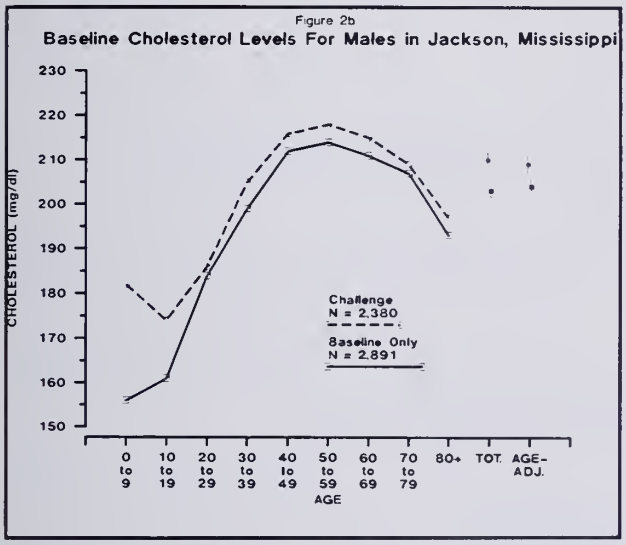


Figure 2b - Baseline Cholesterol Levels for Males in Jackson, MS.

pants who returned for a follow-up cholesterol determination) had higher baseline cholesterol levels than participants who did not return for the follow-up.

A greater percentage of baseline participants from Jackson returned for the follow-up screening than from Lansing [6244 (46%) vs. 2404 (36%), respectively, $p<0.01$] (see Table 2). Comparing sociodemographic characteristics of Challenge participants to baseline-only participants, Challenge participants were older (66 years vs. 57 years), more likely to be married (84% vs. 70% in men, 67% vs. 63% in women), more health conscious (62% vs. 48%), currently smoked fewer cigarettes (12% vs. 15%) and had higher age-adjusted plasma cholesterol (213 vs. 206 mg/dl, $P<0.01$) (see Figure 2a and 2b).

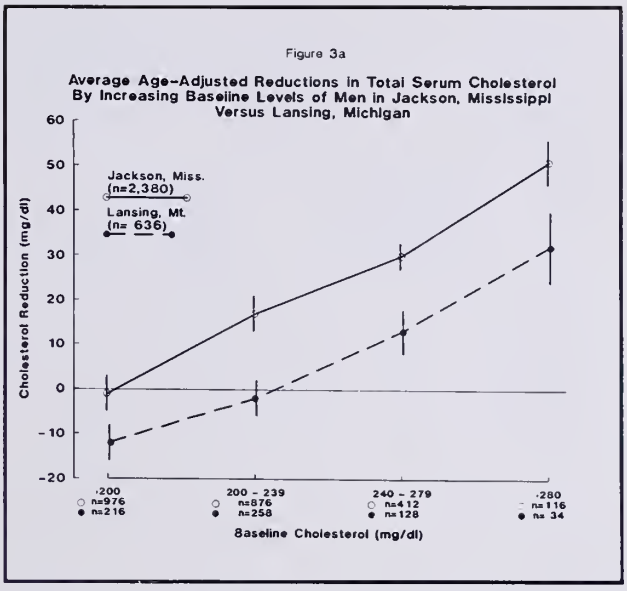


Figure 3a - Average Age-Adjusted Reductions in Total Serum Cholesterol by Increasing Baseline Levels of Men in Jackson, Mississippi Versus Lansing, Michigan.

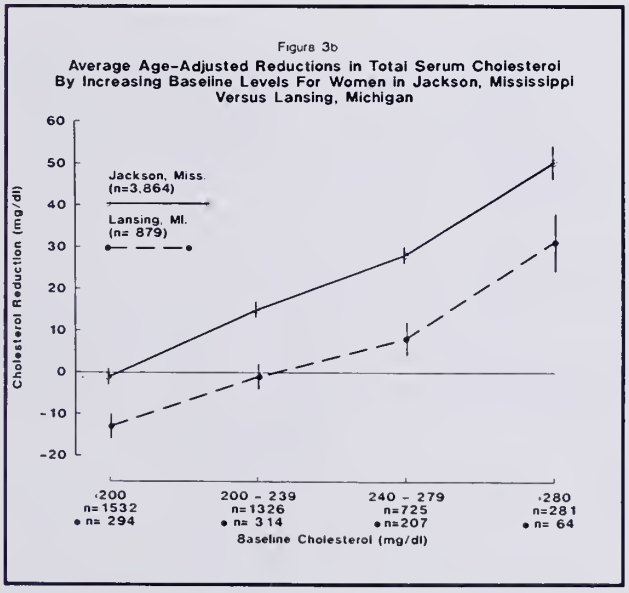


Figure 3b - Average Age-Adjusted Reductions in Total Serum Cholesterol by Increasing Baseline Levels for Women in Jackson, Missisippi Versus Lansing, Michigan.

As shown in Figures 3a and 3b, there was a linear reduction of the age-adjusted plasma levels in each city with higher baseline levels. In Jackson, male and female participants with normal baseline levels ($\leq$200 mg/dl) had no change in mean cholesterol values. Jackson men with borderline levels (200-239 mg/dl) had approximately a 7% reduction whereas participants with levels between 240 and 280 mg/dl had an 11% reduction. For Jackson women, the reduction in cholesterol levels were similar. An interesting phe-

TABLE 2 COMPARISON OF SCREENEES WITH AND WITHOUT FOLLOW-UP IN THE CHOLESTEROL CHALLENGE HEALTH EDUCATION PROGRAM.

	Participation City In Follow-up	N	Cholesterol mg/dl[a] Mean	(SEM)	Age, yrs Mean	(SEM)	High[b] Risk(%)	Smokers (%)	White (%)	Married (%)	College Grad (%)
MEN											
Jackson	Yes	2380	211	(1)	65	(1)	9	13	97	87	55
Jackson	No	2891	204	(1)	55	(1)	7	15	95	79	53
Lansing	Yes	1009c	214	(2)	67	(1)	10	11	97	67	34
Lansing	No	1895	207	(2)	55	(1)	15	14	86	64	40
WOMEN											
Jackson	Yes	3864	214	(1)	65	(1)	10	11	97	67	34
Jackson	No	4575	205	(1)	55	(1)	8	14	95	64	38
Lansing	Yes	1395c	215	(2)	69	(1)	21	10	88	67	30
Lansing	No	2421	207	(2)	58	(1)	18	13	86	63	28

a Plasma cholesterol values were adjusted for age differences between subjects with and without follow-up.
b Subjects with cholesterol levels over 239 mg/dl.
c Demographic features are based on 636 males and 879 females

TABLE 3 EFFECTS OF NUTRITION EDUCATION ON MEAN CHOLESTEROL REDUCTIONS (mg/dl) IN TWO US CITIES.[a]

	No Self-reported Dietary Change or Drug Therapy				Self-reported Dietary Change				Drug Therapy			
LOCATION	N	(%)	mean	(SEM)	N	(%)	mean	(SEM)	N	(%)	mean	(SEM)
Men												
Jackson	1115	(46.9)	6.1	(0.8)	1238	(52.1)	20.2	(0.7)	27	(1.1)	45.8	(6.9)
Lansing	236	(40.3)	-5.4	(1.5)	370	(58.1)	2.8	(1.4)	10	(1.8)	30.4	(10.2)
Women												
Jackson	1398	(36.1)	5.4	(0.7)	2399	(62.1)	17.6	(6.6)	67	(1.7)	44.8	(4.6)
Lansing	323	(36.6)	-8.2	(1.5)	533	(60.5)	1.7	(1.2)	23	(2.6)	31.8	(7.9)

a Mean reductions in plasma cholesterol were adjusted for age and baseline cholesterol level.

nomenon was the slight increase in cholesterol (expressed as a negative reduction) among men and women in Lansing with normal baseline levels. This increase might reflect a regression to the mean effect, or changes in dietary habits preceding the event. Lansing participants with borderline levels showed no change in mean cholesterol levels at the follow-up, whereas participants with higher levels had small but significant reductions.

Frequency distributions of participants who modified their diets or received cholesterol-lowering medication, and their average cholesterol reductions are presented in Table 3. Overall, more women than men reported changing their diets (61% vs. 54% in both cities, $P<0.01$). These changes included 1) eating less red meat, 2) using less fat/oil, 3) eating more fish 4) eating more whole-grain cereals, 5) eating more fruits and vegetables, 6) eating more low-fat dairy products. Approximately 70% of all participants who changed their diets reported 4 or more of the above items.

Participants in Jackson achieved large reductions in cholesterol through dietary changes. Comparing the average reductions in plasma cholesterol between dieters and those who did not diet, after adjusting by analysis of covariance for age and baseline cholesterol levels, the differences were 20 mg/dl and 3 mg/dl in men and 18 mg/dl and 2 mg/dl in women (9%). However, there were little differences in cholesterol reduction by the total number of dietary changes. In Lansing the average reductions in cholesterol were 3 mg/dl for all men and 2 mg/dl for all women (1%), regardless of dietary changes.

Cholesterol-lowering drugs were prescribed in equal proportions in each city (1-2%). Approximately 8% of participants in each city with baseline levels above 240 mg/dl were prescribed cholesterol-lowering drugs. More hypercholesterolemic participants visited their physicians in Lansing than Jackson (42% versus 34%), although more physicians in Jackson remeasured their patient's cholesterol levels (79% versus 68%). Among those men and women who took cholesterol-lowering drugs, there were similar reductions in plasma cholesterol within each city. In Jackson, the mean reduction was 45 mg/dl, and in Lansing the difference was 30 mg/dl.

The Cholesterol Challenge had the additional benefit of promoting positive changes in other health related behaviors. Among current smokers, 7% of men and 8% of women reported cessation of smoking, and 38% of men and 41% of women said they decreased their level of smoking. In addition, 23% of men and 33% of women reported increasing their level of exercise. Among 58 heavy smokers at baseline (over one pack per day) who reported no drug therapy or dietary changes, the sixteen who quit smoking achieved a greater average reduction than those who continued to smoke (21 mg/dl versus 0 mg/dl, $P<0.05$).

Participants in both cities had favorable attitudes toward the media-sponsored health promotion activities offered during the 6 month intervention period (such as the television, radio, and newspaper announcements, the nutrition seminars, as well as newsletter, fliers, and cholesterol information offered in newspaper announcements, and selected breakfast cereals). For example, 41% in Jackson and 35% in Lansing thought such efforts were "very worthwhile" and relatively few thought they were of no value (5% and 11%). The small differences between each city likely reflect the volume of media events rather than differences in quality between the media campaigns of each city.

DISCUSSION

Although equal proportions of participants between cities reported making changes in their diets by reducing their consumption of red meats, oil and fat, and eating more fruits and vegetables, there was a much greater reduction in average plasma cholesterol levels among Jackson participants than Lansing participants. The differences in the apparent effect of diet may be due to reporting bias or may reflect initial differences between the 2 groups. More participants from Lansing entered the Challenge out of concern from previously determined elevated cholesterol levels. It is likely that a greater percentage of Lansing participants may have reduced their cholesterol levels prior to the Challenge by dieting, weight loss, increased physical activity levels or other means. Any further dietary changes (imagined or real) would have little impact on cholesterol levels. However, in Jackson, the heightened media campaign, the participation of companies, more nutritional seminars, and sustained active promotion of the trial by the Health Commissioner (Dr. Lee) were apparently very effective in motivating a large number of persons to have their cholesterol levels measured and reduced. However, the effects of specific dietary changes were difficult to quantify in this study since dietary changes were highly correlated. We were only able to discern the effects of dieting in general. In Lansing, reductions in cholesterol levels were achieved for some participants and the Challenge was successful in motivating many people to have their cholesterol levels deter-

mined.

Since the Challenge was conceived as a demonstration project with intended benefits for both cities, it cannot be evaluated whether the intensive intervention in Jackson was more effective than in Lansing. Lansing did not serve as a "control" group, since both cities conducted an educational campaign, and the self-selected participants were not comparable between cities. If the project was designed as an experimental trial, there would not have been an intervention in Lansing and the competitive spirit of the Challenge would have been eliminated. Further, the public health impact on cholesterol reduction would have been smaller in both cities. A true "control" group is such studies may be impossible to obtain regardless. In the MRFIT trial, control subjects lowered their cholesterol levels substantially, simply by participating in the trial and subsequently increasing healthy lifestyle behaviors.[2]

The Cholesterol Challenge was conceived as a community health education program whose effectiveness was demonstrated by public enthusiasm and sustained educational messages provided through the media. A self-selected proportion of the population, who are predominately women, health conscious, older, and nonsmoking, participated in this community cholesterol reduction program. The results of the Challenge exceeded our expectations. A large number of participants from each city had their cholesterol levels determined, and the participants in Jackson who reported dietary modification, smoking cessation, and/or use of prescribed cholesterol-lowering medication showed impressive average reductions in their cholesterol levels. (Part of this reduction might be attributed to a regression to the mean). While the long-term effects of the Challenge on blood cholesterol levels and CHD incidence and mortality will not be measured, this demonstration suggests that a short term reduction in plasma cholesterol can be achieved for a substantial segment of the population in a cost-effective* manner.

The results of the Challenge are not generalizable to the entire population. Our experience suggests that highly self-motivated person who are knowledgeable regarding their own blood cholesterol levels can substantially reduce their levels, given the appropriate educational materials and conditions (e.g. in this case, the competitive environment). We stress that the results are limited to highly motivated individuals, as the attrition rates for both cities exceed 50% and the dropouts were less likely to be health conscious. While it is difficult to determine which educational intervention was most effective, the participants generally had favorable attitudes toward all medias.

American Health Foundation
320 East 43rd Street
New York, NY 10017

ACKNOWLEDGEMENTS

The Cholesterol Challenge Program was made possible by support of the Kellogg Company, Battle Creek, Michigan and the Eastman Kodak Company, Rochester, New York.

We gratefully acknowledge the cooperation of Dr. Mary Alice Lee and Mayor Dale Danks of Jackson, Mississippi, and Ms. Nancy Bracke and Mayor T. McKane of Lansing, Michigan as well as other community leaders who organized and motivated the local screenings and education programs for their cities. We also thank Ms. Rosalind Fieland for the graphics and illustrations. ❑

REFERENCES

1. Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol In Adults. *Arch Intern Med* 1988;148:36-69.
2. Caggiula AW, Christakis G, Farrand M, et al. The Multiple Risk Factor Intervention Trial (MRFIT). *Prev Med* 1981;10:519-543.
3. Alzonfon J, Tilton KA, Haley NJ. Enzymatic determination of cholesterol in plasma obtained by fingerstick. *Clin Chem* 1985;31:168.
4. NIH Consensus Development Conference: Lowering blood cholesterol to prevent heart disease. *JAMA* 1985;253:2080-2086.
5. SAS User's Guide: Statistics, Version 5 Edition, Cary, NC: SAS Institute, 1985.
6. Wynder EL, Field F, Haley NJ. Population screening for cholesterol determination. *JAMA* 1986;256:2839-42.
7. Wynder EL, Harris RE, Haley, NJ. Population screening for plasma cholesterol: Community based results from Hartford, CT. *AM Heart Journal* 1989;117:649-656.
8. Muscat JE, Harris RE, Haley NJ, Wynder EL. Population screening for plasma cholesterol: Community based results from Memphis, TN. *J Tenn Med Assoc* 1989;82:633-639.

From the Division of Epidemiology and Section of Clinical Biochemistry.

* Estimated Costs: approximately $14 per measurement which includes the costs for personnel, media and in-house staff.



Partners In Health Care

Mississippi's meager resources and enormous health care needs demand that all physicians — in private practice and those in the public sector — focus efforts on the same health care goals.

In previous editions, we've talked about *why* and *how* and *who*. We believe that our public-private partnership helps make life better for our families and friends. We can and do share the credit for having achieved so much with so little.

But we need to hear what you have to say. Please clip or copy this page and tell us what you think we all *need* to and *can do* to become better Partners In Health Care. Mail or fax your response to Health Communications, MSDH, P. O. Box 1700, Jackson, MS 39215-1700, fax 601/960-7434.

Together, we can!

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH



The President's Page

JAMES C. WAITES, MD

A Prescription For The Physician

As I have traveled around and talked with many of you in the past few months, I have noted a disturbing syndrome that seems to be effecting all of us. This syndrome seems to be universal. I saw the same symptoms, heard the same history and witnessed the same physical problems at the recent AMA Leadership Conference with people from all over this country.

The symptoms consist of blurred vision, confusion, loss of motivation, restlessness, fatigue, insomnia, headache, and even weight loss. The history began about 6-12 months ago when we had an invasion of the bureaucracy into our practices and reached its peak around January 1, with the implementation of RBRVS and the EM codes. Since that time, the symptoms have become more obvious and more uniform. The course of the process has ranged from severe - withdrawal from practice, to mild - actually some pleasure and challenge with the new system. The usual course, however, consist of threats to withdraw from practice, threats to cease accepting medicare or medicaid, or of limiting access of these into our practices.

Dare I offer a prescription to combat this syndrome? Who am I to be so bold to feel that I might have something to offer? Yet, I would be remiss, as your elected representative, not to have heard and learned from others and from my own experience, and then not offer to share with you. Remember, I am offering a prescription, not a cure. There is a difference. A cure is a guarantee. A prescription, if followed, holds out the possibility of improvement. A prescription also requires cooperation. You have to be willing to take it.

The first thing to do is to reexamine the reasons that brought you into medicine to begin with. Most of us are of such a temperament and drive, that we could make a living (and a pretty good one, I would add) doing other things. Yet for the most of us, we would not and perhaps even could not be happy doing anything other than practicing medicine. The same fascination in dealing with people and with their problems of illness, both physical and psychological is still there in spite of the efforts of the third party intrusion. Remember that another person, with one brief life has entrusted that life and their happiness to you. Therefore, their happiness and yours is in your hands. The reason for this is that whatever we do, we usually do it for the approval of others. However famous we are, however accomplished in our profession, whoever lavishes us with adulation, it is meaningless unless we have the approval of the people who matter most to us, our patients. If we have their encouragement, sympathy, understanding and support, then nothing is too hard for us. But if we do not, our initiative is drained, our courage diminished and we are ineffective in the war against those who would change the system.

Get back to the basics, the one-on-one encounter, the one frail, fragile, fleeting life, the one person who has trusted you and realize that your support, concern, understanding and empathy are as vital to that person's well-being as their encouragement and acceptance are to yours.

(Continued on page (98)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 3
MARCH 1992

Ethics and Economics

In the debate over reforms in health care reimbursement, the issue of fee-for-service versus prepaid reimbursement continues unresolved. Both systems have advantages and disadvantages. Consideration of this issue makes it obvious that both fee-for-service and prepaid care allow room for unethical behavior to provide inappropriate (fee-for-service) or inadequate (prepaid care) service for the payment rendered. In the case of fee-for-service, the unethical professional can initiate and provide unnecessary services, whereas in the case of prepaid care, the unethical professional can gain a monetary advantage by withholding needed services.

It appears that unethical behavior can probably take advantage of any reimbursement system, leading to the conclusion that the regulation or correction of unethical behavior should not be a primary goal of reimbursement systems. Instead, the regulation of unethical behavior appears to be a policing problem not an economics problem. The solution to this problem will require a system which incorporates at least the following features: (1) defined standards of ethical behavior, (2) the ability to measure, in a timely fashion, the compliance of professionals with the standards, and (3) the ability (and authority) to apply appropriate corrective action, both educational and, if necessary, punitive, in a meaningful fashion. Only the medical profession can (and should) develop and implement such a system to promote the ethics of its members.

For the good of our profession, regulation of the ethical behavior of our members must be a primary concern if we are to maintain the respect of the people we serve. We should urge our elected governmental representatives to assist us in the implementation of an effective and autonomous system of professional ethical regulations for physicians.

George Abraham, MD
Associate Editor

The Best Medicine Sometimes Can't Be Bought

A pharmacist friend shared a recent event with me in which a patient presented with prescriptions for approximately a month's supply for four different medications. The female patient appeared to be about 55-60 years old and was being treated for hypertension, diabetes mellitus, arthritis, and nutritional deficiencies.

Her physician had prescribed a "new wave" antihypertensive agent in combination with hydrochlorothiazide, a "new generation" oral antidiabetic agent, one of the newer nonsteroidal anti-inflammatory agents, and a mineral supplement. Upon advising the patient of the cost of the medications that had been prescribed (a total of approximately $140 for a month's supply), the pharmacist was asked to dispense what the patient could afford -- about $40 worth of the medications. This turned out to be little more than a week's supply - the first and last "week's" supply the patient apparently ever received.

As I write this, approximately three weeks have passed since this incident and the patient has not returned for refills of her prescriptions. The doctor has provided no additional services to the patient. And the patient cannot be contacted. Indeed, every indication suggests that the patient has simply decided that she cannot afford

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

the medication she needs. And the end result?

Numerous reports in the literature cite that major role high prescription costs play in patient non-compliance. And this woman's case is but one example of what pharmacists tell me are fairly common events.

While many physicians are generally aware that some medications are more expensive than others, it's difficult for most of us to maintain current knowledge of the topic. The pharmaceutical manufacturers' representatives are a major source of information on the issue, but their information is subject to bias. Indeed, as a member of the Mississippi Medicaid Formulary Advisory Committee, I was told within a one week period by representatives of every manufacturer of a histamine-2 receptor antagonist that his company's product was the least expensive. How can that be? You may need to get drug prices from your local pharmacist.

Physicians are also aware, as are our patients, that prescription medication prices are escalating at an alarming rate. In fact, in the ten year period beginning in July of 1980, prescription prices increased by 152% while the general inflation rate was 58%. Local pharmacists get only about 3% profit so when it comes to prescription costs, there's not much doubt where the "fat" is.

As prescribers, we physicians must use great discretion in our selection of pharmaceutical products and the relative costs of the therapeutic alternatives available must be weighed heavily. Our prescribing decisions directly affect the pocketbook of private pay patients and the premiums for the privately insured. Surely the recent federal mandate putting many of the most expensive medications on medicaid is destined to bankrupt the program unless we physicians take this into account when we prescribe medications for these patients.

It is up to you and I to prescribe the most effective yet the most economical medications available for our patients. As you know no matter how through our knowledge of pharmacology, no matter how skilled we are in making accurate diagnoses, no matter how advanced certain pharmaceutical products may be, if the price of the product we select is beyond reach of the patient ..... we have failed.

Thank God I am a physician.

Joseph E. Johnston, MD
Associate Editor

Presidents's Page

(Continued from page 96)

The second part of the prescription is to remember that we are a profession, not just job. We deal with people, life, and its fragile parts, not just disease and its effect on our physiology. We are each different, created uniquely, to be the persons that we are, yet in many ways we are far more alike than we are different. We share in the joy of a birth, we weep in the loss of a mother, father, child, and we rejoice in the miracles of modern medicine that allow one to return to the enjoyment of life when a few years ago there would have been no hope. The effort requires more from us than can be compensated for with money, but the rewards are things that money could never buy -- the smile, the hugs from a child, and the thank you that comes from the heart. We have jobs to do, but we are a profession, and we will do that job to the best of our ability.

The third part of the prescription is to recognize that none of us can meet all the needs of the other. Sometimes we think human character and personality are so rich that one person has everything and will meet all the expectations of the other. That is never true. No one person is endowed with all gifts and abilities. When our egos become so large that they obliterate our conscience, we are bound to disappoint and disappointment leads to resentment which often leads to litigation. Medicine represents partnership, not competition. We can each share in the care of those we call patients.

Fourth is to reinforce the shared values that we all posess. This does not mean that we all become carbon copies of each other. On the contrary there are many areas in the field of medicine that we can all pursue, and they all can reflect common values. We believe in the free enterprise system where the patient has a choice of physicians, we believe that health care should be provided for all, and that care of the poor is a social problem that should be addressed by society, we believe that contracts should be between patient and physician and that insurance should be used to help defray the cost of medical care. These are but a few of the common values that we can rally around.

Finally, let us cherish and nourish our profession. Cherish has variously been defined as "to value highly, to nurture with tenderness, to hold in one's heart." Perhaps you would question my choice of words here, but I firmly believe that we much cherish and nourish our profession as we do our mates. We must love it enough that we will correct and discipline as we would our children when it is necessary, but support and lift up each other when we are assailed from outside the profession.

Well, there's the prescription! It is far from perfect; but it doesn't need to be perfect. All of you can and should add your own list. We just need to take it seriously. Make a start with it, and see what it will do for you.□

St. Dominic Hospital introduces a new way to live - and live well - with arthritis

St. Dominic's new ArthritisCare Center is specially staffed and equipped to give your patients the support they need to lead a better life with arthritis.

Anyone who has ever experienced the chronic symptoms of arthritis knows that the most difficult part of the disease goes beyond joint pain.



That's why at St. Dominic ArthritisCare Center, your patients are given the most effective tools necessary to better manage and cope with the pain of arthritis: knowledge and treatment.



St. Dominic ArthritisCare is a comprehensive inpatient and outpatient program designed to provide education, treatment and support for people with arthritis of all types. The ArthritisCare Center is the only center of its kind in Middle Mississippi that offers a comprehensive program for arthritis treatment.

Employs, with the referring physician, a team management approach to patient care.

At the ArthritisCare Center, your patients get a complete program that combines several effective treatment approaches that enable them to live a more satisfying, fulfilling life in spite of arthritis. Each member of the Center's staff - nurses, therapists and educators - is specially trained in rheumatic disease and works exclusively in the Center.

St. Dominic ArthritisCare Center accepts referrals from all physicians. The professional staff of the ArthritisCare Center works closely and carefully with the individual's referring physician in administering the most effective treatment plan for their patients.



Treatment programs may include all or some of the following services:

- Education and counseling. We help patients and their families understan this condition and the effect it can have on their lives.
- Pain management. Patients learn to control and minimize pain.
- Physical and occupational therapy. Therapy is available to help patients live - and work - with arthritis.
- Medical/Pre-surgical education and treatment. Helps prepare patients for upcoming surgery and treatment.

To admit your patient to the ArthritisCare Center call

(601) 364 - 6732

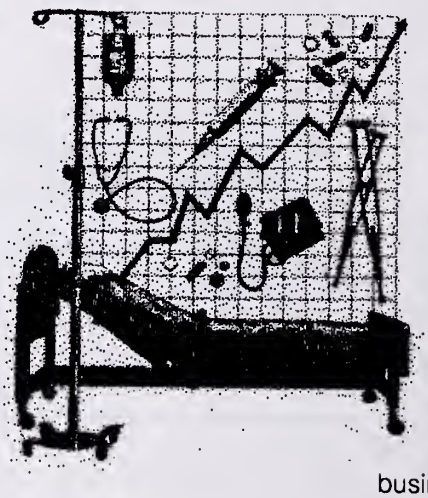
ArthritisCare Center
St. Dominic - Jackson Memorial Hospital
969 Lakeland Drive
Jackson, Mississippi 39216

Doctors pay less for health care coverage, right? Wrong!

When compared to the national average, health care costs are higher for physicians and their office staff, than most other businesses or professions. In fact, over 40 million people in the U. S. are without health care insurance coverage today, because of high costs.

CONGRESS PROPOSAL PENDING

If congress has it way, it will be the responsibility of all business owners, including doctor's, to either partially or fully provide — or make available — health care coverage for employees. Every program, from "employer-mandated" coverage, where the employer must provide some acceptable format of coverage through a conventional carrier, to a "state-subsidized" program funded by monthly contributions from employers is under consideration.



EMPLOYEE BENEFITS HAVE BECOME A POSITIVE FACTOR

Because of the instability of health care costs and the awareness of lack of coverage to so many people, employee benefits have become a "major consideration" for the attraction and retention of quality employees. This is even more true in the medical field, because of the high costs of health care insurance for this particular group.

HOW THIS ISSUE CONCERNS YOU

When many small business, medical groups and other professionals join together to provide quality health care services and other employee benefits "much" can be accomplished. This is exactly what happens through the concept of "employee contract services". Employer Plus provides these services through the nation's leading health care insurance carrier, CIGNA — one the most financially secure insurance companies in the U.S. today — and we do so for many smaller businesses, doctors, medical groups, and other professionals, here is Mississippi.

HOW TO REQUEST MORE INFORMATION

Employer Plus would be glad to send you information on how "employee contract services" specifically relates to your medical practice and employees. Just call or write. We promise to respond quickly, and with no obligation.

Employer Plus, Inc.

No one administers payroll and employee benefits, better! SM

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293 • 1-800-844-0093

©1991 Employer Plus, Inc. All rights reserved

"Current Opinions" of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON PRACTICE MATTERS

Referral of Patients-Disclosure of Limitations

When a physician agrees to provide treatment, he thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his ability. PPO and HMO contracts generally restrict the participating physician's scope of referral to medical specialists, diagnostic laboratories, and hospitals that have contractual arrangements with the PPO and HMO. Some Plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the PPO or HMO does not permit referral to a noncontracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his own expense or confine himself to services available within the PPO or HMO. In determining whether treatment or diagnosis requires referral to outside specialty services, the physician should be guided by standards of good medical practice.

Substitution of Surgeon Without Patient's Knowledge or Consent

A surgeon who allows a substitute to operate on his patient without the patient's knowledge and consent is deceitful. The patient is entitled to choose his own physician and he should be permitted to acquiesce in or refuse to accept the substitution.

The surgeon's obligation to the patient requires him to perform the surgical operation: (1) within the scope of authority granted by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of facts relevant to the need and the performance of the operation; and (4) utilizing his best skill.

It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The operating surgeon, in accepting the patient, is obligated to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. He cannot properly delegate to another the duties which he is required to perform personally.

Under the normal and customary arrangement with patients, and with reference to the usual form of consent to operation, the operating surgeon is obligated to perform the operation but may be assisted by residents or other surgeons. With the consent of the patient, it is not unethical for the operating surgeon to delegate the performance of certain aspects of the operation to his assistant provided this is done under his participatory supervision, i.e., he must scrub. If a resident or other physician is to perform the operation under non-participatory supervision, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent. Under these circumstances, it is the resident or other physician who becomes the operating surgeon. ❑

Mississippi Foundation For Medical Care, Inc.

Physicians Needed - Join Your PRO Today

MFMC, as the designated Peer Review Organization for the state, reviews hospital admissions under private, state and federal contract to ensure cost effective quality medical care for all Mississippians.

MFMC has nearly 2000 physician members with 25% of them involved in physician review. Members elect the MFMC Board of Directors, thus influencing the policies of the PRO. MFMC invites all licensed Mississippi physicians to join and have a voice in their PRO.

Make a difference and join MFMC today. There are no membership fees. For more details, call MFMC Communications at 354-0304.

MFMC is Mississippi Physicians working together to ensure the highest quality health care for all Mississippians.



ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

AXID®
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

1. Data on file, Lilly Research Laboratories.

See accompanying page for prescribing information.

© 1991, ELI LILLY AND COMPANY

NZ-2947-B-249304

AXID®

nizatidine capsules



Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

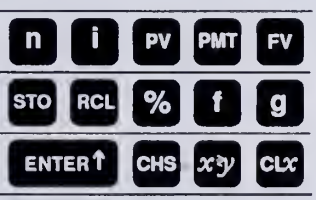
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- **No-Load Mutual Funds/Other Securities**
- **23 Years Experience**
- **Tested Asset Allocation Model**
- **Fee-Only Advisor**

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123

Medical Organization

UMC Langford Professorship In Medicine

The University of Mississippi Medical Center has received a $200,000 challenge grant form the Chisholm Foundation and the Margaret A. Chisholm Trust to help endow the Herbert Gaines Langford Professorship in Medicine. The grant will match contributions to the professorship on a dollar-for-dollar basis.

Dr. Langford, who died in January, 1992, was a world authority on high blood pressure. He had been on the Medical Center faculty since the institution opened in 1955 and taught every medical student through the class of 1991.

"We are pleased that the Chisholm foundation and the Chisholm Trust have chosen to take such an active and generous role in establishing the Langford Professorship," said Chancellor R. Gerald Turner. "Their commitment is indicative of both the esteem in which Dr. Langford was held and the importance of his research on hypertension."

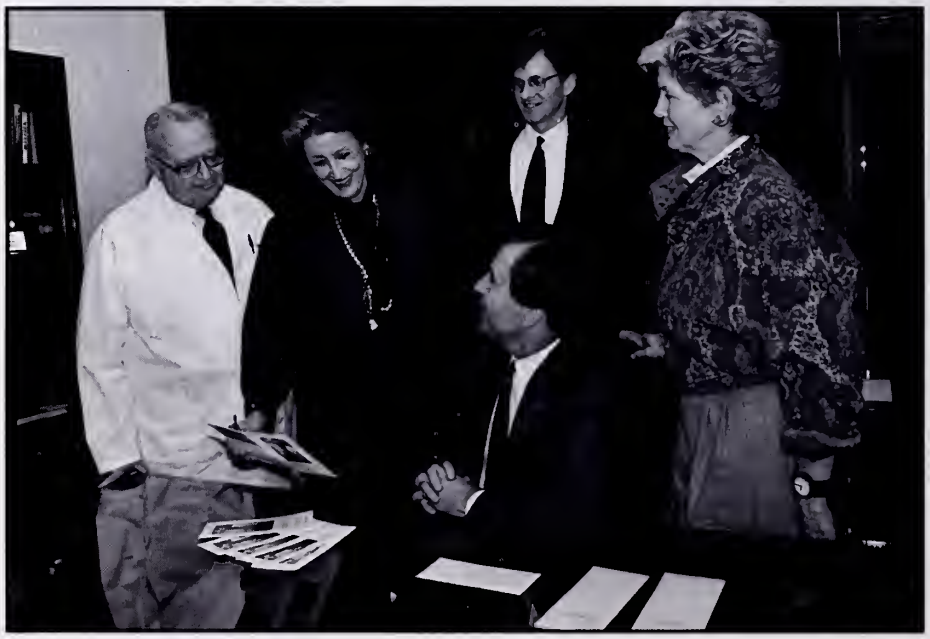
"High blood pressure is an enormous health problem in Mississippi, " said Dr. Norman C. Nelson, UMC vice chancellor for health affairs. "This endowment will help assure that the School of Medicine can recruit a physician-scientist who has the potential to conduct the caliber of hypertension research which was the focus of Dr. Langford's long and distinguished professional career."

Dr. Langford was a Barnard Distinguished Professor, professor of medicine and director of the Division of Endocrinology and Hypertension at the Medical Center at the time of his death. In 1987, he received the award for individual achievement from the National High Blood Pressure Education Program in recognition of his research which enhanced medicine's understanding of the dietary factors which influence high blood pressure. He was among the first to suggest that the prevalence of high blood pressure among African Americans may differ from its prevalence among other ethnic groups, and he drew attention to the differences in potassium intake as a possible explanation for difference in high blood pressure among ethnic groups.

Dr. Langford served as chairman of the National Heart, Lung, and Blood Institute's hypertension Detection and Followup Program (HDFP) Which proved conclusively that vigorous treatment of mild high blood pressure could decrease the death rate from coronary heart disease. The institute received the 1980 Lasker Special Public Health Award for the HDFP.

After HDFP, Dr. Langford headed the Medical Center's participation in several other multicenter studies funded by the National Institutes of Health (NIH) which ultimately proved that diet, weight loss and exercise can help prevent hypertension.

Dr. Nelson said the goal for the Langford Professorship is a minimum of $500,000. ❑



UMC Receives Challenge Grant The Chisholm Foundation and the Margaret A. Chisholm Trust have awarded the University of Mississippi Medical Center a $200,000 challenge grant to help endow the Herbert Gaines Langford Professorship in Medicine. Dr. Langford, a world authority on high blood pressure, died in January, 1991. Jean C. Lindsey of Laurel (at second left) is president and managing trustee of the Chisholm Foundation. With her are (from left) Dr. Norman C. Nelson, UMC vice chancellor for health affairs, (Mrs. Lindsey), Chancellor R. Gerald Turner, Mrs Herbert Langford of Jackson, and her son (standing in background) Dr. Jon Langford of Durham, NC.

Dr. Gunn Elected President of Medical Alumni Chapter

Dr. Walter D. Gunn of Quitman has been elected president of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

A graduate of Charleston High School, Dr. Gunn earned his BS and BA at Ole Miss, where he also earned the Certificate of Medicine in 1948. He earned the MD at the University of Tennessee, then began his medical practice in Quitman in 1952. He has since been Chief of Staff at the Watkins Memorial Hospital in Quitman numerous times during his medical career.

Dr. Gunn is a fellow of the American Academy of Family Physicians and past president of the East Mississippi Medical Society and Mississippi Academy of Family Physicians. He holds professional memberships in the American Medical Association and the Mississippi State Medical Association.

Active in the community, Dr. Gunn is a Mason and member of the Meridian Community Choir and is past chairman of the Clarke County Heart Association and former member of the Board of Review for the Boy Scouts of America. He is an active member of the First United Methodist Church and presently serves as a teacher and choir member.

Dr. Gunn and his wife, the former Joanne Darby Wilcox, are the parents of two children, Linda Gunn Haddock of Lake Village, AK, and Dill Gunn of Jackson, and have three grandchildren. ❑

Woodrell Named Director of University Hospitals and Clinics

Frederick D. "Ted" Woodrell, new director for the University Hospitals and Clinics, won't have a lot of Florida memorabilia adorning his new office because "that era is closed and a new one has begun," he says. He's simply looking forward to the future.

The former Florida hospital executive announced his new position on January 6, 1992. He has since spent his days getting to know the hospital and its employees.

"We are very pleased to have a hospital administrator of Mr. Woodrell's background and experience joining us as hospital director," said Dr. Norman C. Nelson, vice chancellor for health affairs, "We believe he will do an exceptional job."

Woodrell had been president and chief executive officer for the 414-bed Central Florida Health Care Development Corporation in Leesburg, Fla., since 1985. He has worked since 1979 with Quorum Health Resources, Inc., which has a consultative management agreement with The University Hospital.

"Many of the operational issues here are similar to those at Central Florida, but the magnitude and volume is much greater and more complex," Woodrell said. "I look at the operations here and see a wealth of resources. We're in a unique position in Mississippi -- and in the health care market as a whole -- because we are the only provider in so many service areas. With our teaching component, there's a lot offered here that's available nowhere else in the state."

Woodrell, who earned the BS in 1976 at Emporia Kansas State College and the MPA in 1977 at the University of Missouri, Kansas City Graduate School of Public Administration, took his administrative internship at Lakeside Hospital in Kansas City, Mo. In 1977, he joined the staff of Robert Brown Consulting of Kansas City, and was a research assistant in the School of Administration in Kansas City from 1977-1978, while completing his administrative residency at the Independence Sanitarium and Hospital in Independence, Mo. In 1978, he joined the HCA management team as assistant administrator at Lee's Summit Community Hospital in Lee's Summit, Mo., and in 1979, was appointed assistant administrator at Leesburg Regional Medical Center in Leesburg, Fla. He was promoted to administrator of the facility in 1982.

'I'm proud of what we were able to accomplish in Florida, but I'm really excited about what we can accomplish here. There are a lot of challenges to be dealt with, but I'm delighted to be here,'"Woodrell said.

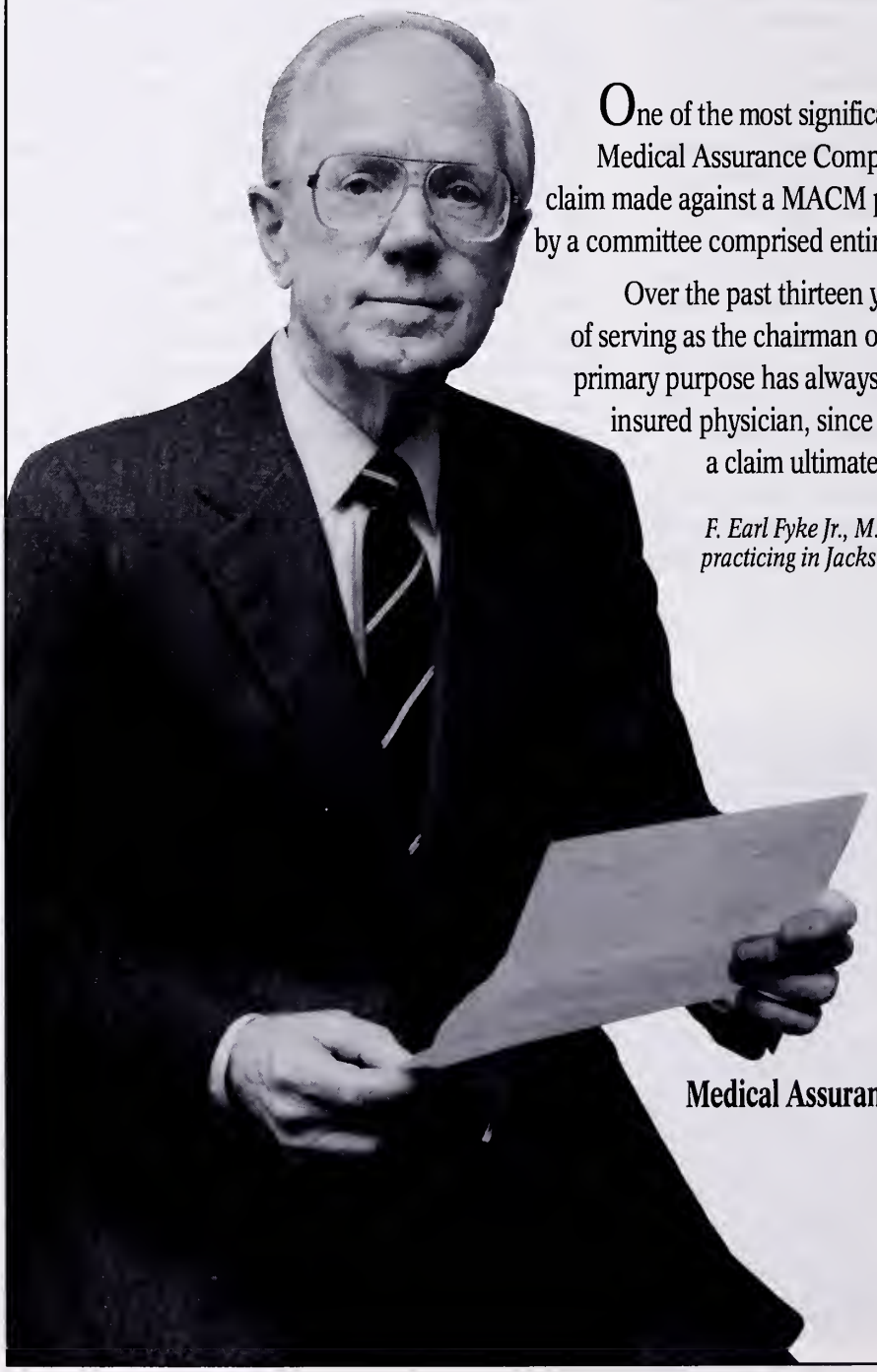
Woodrell holds professional memberships in the American College of Healthcare Executive and the American Hospital Association.

He and his wife, Brenda, have three children: Sara, 12, Grace 10, and Evan 6. ❑

The Delta Region AIDS Education and Training Center grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN, Resource Center Director
(601) 984-5560 (601) 984-5565 FAX
2500 North State Street, Jackson, MS 39216-4505

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915



Dr. C. G. Sutherland Retires as MACM Medical Director

On February 1, 1992, Dr. C. G. Sutherland retired as Medical Director of the Medical Assurance Company of Mississippi (MACM). Dr. Sutherland has served as Medical Director since 1983, but his association with the company goes back much further. From 1977-1979 he served on various committees within MACM while he was in the private practice of obstetrics and gynecology at the Jackson Woman's Clinic.

Just prior to his retirement from MACM, Dr. Sutherland reminisced about the formation of the Medical Assurance Company of Mississippi and his association with the company.

In 1983, when he began working as Medical Director, there were just 750 policy holders. During his years as medical director, Dr. Sutherland has watched MACM grow to more than 1600 policy holders. As a result of his serving on various committees for the newly formed insurance company, Dr. Sutherland was sure that MACM could really meet the needs of Mississippi's physicians. He said, "I liked the philosophy of the company, its responsiveness to policy holders and its continuing encouragement of physician participation through committees. I was pleased to join the company full-time as medical director."

"I remember during the first few years, the company had to raise premiums about 20% each year to cover actuarial based losses. Then about three years ago, I was glad to see premiums stabilize. We didn't need to raise premiums and last year and the company even reduced premiums for some areas of coverage; unfortunately it won't last." Dr. Sutherland said, "Even though my responsibilities, of course, have been more in the medical area, I've learned a lot about insurance. Over the past few years, I've learned about the cyclical nature of the insurance business and we will begin to see the trend of increased losses and premium increases again." He pointed out that the company was originally formed to benefit its policyholders and that the company would continue to operate in their best interests. "The company is well run, the staff is knowledgeable and dedicated, and the future looks bright," Dr. Sutherland said.

As medical director, Dr. Sutherland worked with the risk management committee, reviewed applicants for membership and was available to claims committees. He said, "Quality assurance is practicing good medicine and practicing good medicine reduces risks".

When reflecting back over the years he has served as medical director, Dr. Sutherland said, "If I had the opportunity, I would do it all over again. I've made some great personal associations with physicians all over the state."

In the future, Dr. Sutherland will work on a consultative basis for MACM. About retirement, Dr. Sutherland says, "I'm going to take each day at time and we've got some family to visit." ❑



THE UNITED STATES ARMY RESERVE
HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM
$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

IT TOOK YOU MANY YEARS TO BECOME A PHYSICIAN...

MPIC
Mississippi State Medical Association Sponsored Insurance Plans

Why spend one more minute looking for LIFE INSURANCE?

The Mississippi State Medical Association, Manhattan National Life, and BellMED Insurance Resource Center Inc., have joined together to offer MSMA endorsed SIMPLIFIED ISSUE Term Life plans. Our current SUPERSAVER XV long term, low cost plan offers MSMA members, their staff and spouses these benefits...

★ **GUARANTEES**

— In these days of economic and financial uncertainty, we are pleased to offer you a 15 YEAR RATE GUARANTEE

— Your premium stays level and cannot be increased for the next 15 years...and that's guaranteed

— The coverage is guaranteed renewable to age 95

★ **SIMPLIFIED ISSUE**

— NO EXAM or BLOODWORK*

— NO SALESPERSON VISIT

— ONE PAGE APPLICATION

★ **VERY LOW RATES**

— example: $200,000 preferred non-smoker — annual rate guaranteed for 15 years

Age 40	=	**$400**
Age 45	=	**$554**
Age 50	=	**$800**

IF YOU HAVE ALREADY TAKEN ADVANTAGE OF THE PROGRAM...*THANK YOU!*

BELLMED

If you have not, we think SIMPLIFIED ISSUE SuperSaver XV makes sense. For rates and information, call BellMED at

1-800-456-8042

Manhattan National Life

*Manhattan National Life does reserve the right to request additional information

MSMA 124th Annual Session
April 29 - May 3, 1992
Ramada Renaissance, Hotel
Jackson, Mississippi

Program Overview

Wednesday, April 29

1:00 pm - Exhibitor Set-up
- MSMA Golf and Tennis Tournaments

Thursday, April 30

7:00 am - Exhibits Open
8:00 am - MSMA Registration Opens
9:00 am - **MSMA HOUSE OF DELEGATES** - Ballroom A

1:00 pm - Mississippi Foundation for Medical Care Membership Meeting - Ballroom A
2:00 pm - **PARAMETERS OF CARE** - Panel discussion Open to all participants. Hosted by the Young Physician's and Hospital Medical Staff Sections - Ballroom B
3:30 pm - Young Physicians Section Business Meeting - Ballroom B
- Hospital Medical Staff Section Business Meeting - Ballroom A
4:00 pm - **MSMA REFERENCE COMMITTEE A** - Ballroom A
6:00 pm - MSMA President's Reception - Jackson Zoo

Friday, May 1

7:00 am - Exhibits Open
8:00 am - MSMA Registration Opens
8:00 am - **MEDICINE PLENARY SESSION** - Seminar Rooms I and II

Friday, May 1 *continued*	Noon	- MS Academy of Family Physicians Luncheon
		- MS Psychiatric Association Luncheon
		- MS Society of Internal Medicine Luncheon
	1:00 pm	- **MSMA REFERENCE COMMITTEE CONSTITUTION and BY-LAWS)** - Seminar Rooms I & II
	2:00 pm	- **MSMA REFERENCE COMMITTEE B** - Seminar Rooms I & II
	4:00 pm	- MS Physicians Insurance Company Annual Stockholders Meeting - Seminar Rooms I & II
	6:00 pm	- University of Mississippi Medical Alumni Association Meeting
		- Tulane Medical Allumni Association Meeting
Saturday, May 2	8:00 am	- **SURGERY PLENARY SESSION** - Ballroom C **New Technology, Triumph or Trivial Pursuit**
	10:00 am	- MS Dermatological Society Meeting
	Noon	- MS Chapter, American College of Surgeons Luncheon - Annual and Scientific Meetings - Ballroom B
		- MS Dermatological Society Luncheon
		- MS Chapter, American College of Emergency Physicians - Luncheon and Scientific Meeting
		- MS Society of Anesthesiologists Luncheon
	6:30 pm	- **MSMA and MSMA Auxiliary Membership Party** - Grand Ballroom
Sunday, May 3	7:30 am	- Continental Breakfast
	8:00 am	- Protestant Church Service - Ballroom A
		- Catholic Services - St. Richards Catholic Church
	9:00 am	- **MSMA HOUSE OF DELEGATES** - Ballroom A
	Noon	- Meeting adjourned

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

New Members

Bailey, Robert E., Meridian. Born Hattiesburg, MS, July 25, 1950; DO, Kansas City College of Osteopathic Medicine, Kansas City, MO, 1980; interned one year; neurology residency one year University of Arkansas and two years University of South Alabama School of Medicine, Mobile, AL; elected to membership by East Mississippi Medical Society.

Horne, Willus M., Laurel. Born March 16, 1962, in Jones Co.; MD, University of Mississippi School of Medicine, 1988; interned and internal medicine residency Baroness Erlanger Medical Center 7/88 to 12/91; elected by South Mississippi Medical Society.

Parker, Waylon M., Long Beach. Born May 18, 1956; MD, Louisiana State University School of Medicine, New Orleans, LA, 1982; interned and pediatric residency University of Texas Health Science Center, San Antonio, TX, 1982-85; elected by Coast Counties Medical Society.

Pierce, Lee B., Jackson. Born Union, MS, December 22, 1959; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; family medicine residency University Medical Center, Jackson, MS, 1987-90; elected by Central Medical Society. ❑

Deaths

Ford, John Mitchell, Baldwyn. Born Baldwyn, MS, June 28, 1923; MD, Tulane University School of Medicine, New Orleans, LA, 1947; interned Charity Hospital, New Orleans, LA; died November 27, 1991, age 68.

Moore, Ben Junior, Batesville. Born Sardis, MS, July 20, 1921; MD, University of Tennessee College of Medicine, Memphis, TN, 1953; interned one year Baptist Memorial Hospital, Memphis, TN; died February 10, 1992, age 70. ❑





"When I realized my chances of becoming disabled by age 65 were *three times greater* than the chances of death . . .

I compared disability insurance plans. And I decided that my MSMA-endorsed disability insurance plan

SERVES ME BEST!

It's not group insurance, but an individually-owned policy which is *non-cancellable* and *guaranteed renewable.*"

If you're a member of the Mississippi State Medical Association you may be eligible for this outstanding professional disability plan at *discounted premiums*.

- Non-cancellable, guaranteed renewable
- Medical specialty protection
- Presumptive loss provision
- Indexing of prior earnings
- Waiver of premium
- Cost of living rider
- Future disability insurance option
- Lifetime accident and sickness rider
- Total and residual disability protection

Offered by Paul Revere Insurance Company to MSMA members through its exclusive representatives, Professional Disability Specialists.

Jon B. Wimbish, Disability Specialist

1501 Lakeland Drive, Suite 200 Jackson, MS 39216 Telephone 362-9800

Personals

George E. Abraham, II, of Vicksburg has been appointed to the board of trustees of the Vicksburg Medical Center.

James L. Achord, professor of medicine and director of the Division of Digestive Diseases, UMC, was awarded the 1991 Samuel Weiss award for outstanding service to the ACG by the American College of Gastroenterology.

William G. Bush of Jackson a specialist in the practice of Obstetrics and Gynecology, announces the relocation of his office to 1021 North Flowood Drive, Jackson.

Dominic M. Cannella announces the opening of Neurosurgey of Hattiesburg in Medodist Medical Park.

Kenneth R. Cargile and Stephen M. Shirley of New Albany announce the association of the Family Medical Clinic of New Albany with North Mississippi Family Medical Clinics.

Edward L. Carruth announces the opening of Immediate Care Clinic in family practice at 1710 14th Street, Meridian, MS.

Jack Q. Causey, II a Hattiesburg pathologist has been elected a Fellow of the College of American Pathologists.

Moncure Dabney of Crystal Springs was honored at a reception marking his retirement from the active practice of medicine. The reception was hosted by the Crystal Springs Chamber of Commerce, Hilton-Cottingham Post 41 of the American Legion, Crystal Springs Lions Club, Crystal Springs Optimist Club and the Council of Garden Clubs. The occasion marked the close of 46 years of the practice of medicine, mostly in the Crystal Springs area.

Daniel Paul Edney of Vicksburg recently received board certification and diplomate status from the American Board of Internal Medicine.

Wendell Hughes Glover of Vicksburg recently received board certification and diplomate status from the American Board of Internal Medicine.

Ron Graham has associated with **Joe Pulliam** of the Family Medical Center for the practice of orthopedic medicine, Greenville, MS.

Mark Horne has associated with the Internal Medicine Clinic of Laurel, P.A. in the practice of Internal Medicine, 1203 Jefferson Street, Laurel.

Eric Lindstrom an ophthalmologist from Laurel was recently appointed Associate Councilor for the State of Mississippi by the Southern Medical Association.

Annette K. Low of Vicksburg recently received board certification and diplomate status from the American Board of Internal Medicine.

Frank G. Martin, of Gulfport recently completed the recertification process by the American Board of Surgery.

Physicians' Recognition Award

Three MSMA members were named recipients of the AMA Physicians' Recognition Award in January 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These three individuals are presented below by medical society.

COAST COUNTIES
Robert F. Carter, MD
Waylon Morris Parker, MD

CENTRAL
Owen Beverly Evans, MD

John P. Mladineo, of Jackson presented a program on "Cancer Concerns of Women" to the Malabouchia Chapter, Professional Secretaries International.

Obie M. McNair. Jr., has associated with the Mississippi Family Health Center, LTD, Jackson. He is a Diplomate of the American Board of Internal Medicine, subspecialty of pulmonary Diseases.

Hal Moore a Pascagoula radiologist, has been selected to lead the League for Excellence in Academic Development (LEAD) for 1992. LEAD is a group of concerned citizens working towards improvement of public education in Pascagoula and Gautier.

Harriet Murphy of Gulfport received the annual Capt. William Harris Hardy Founder's Award from the Gulfport Rotary Club for her contributions to the community.

Kevin Nichols announces the relocation of his family medicine practice to the Medical Clinic at Thaggard Hospital in Madden.

Joel Payne of Jackson was named 1992 Chief of Staff at Woman's Hospital.

William Edwin Powell of Waynesboro has been recertified by the American Board of Family Practice.

Felix H. Savoie, III, of Jackson was inducted as a fellow of the American Academy of Orthopaedic Surgeons during ceremonies at the Academy's 59th annual meeting in Washington, D.C.

Craig M. Slater of Gulfport recently attended a course entitled *Current Trends in Total Hip Arthroplasty.*

Maurice E. Snyder of Meridian announces his retirement from the practice of family medicine.

Mary Ann Frank Tarsi of Grenada has been recertified as a diplomate of the American Board of Family Pracitice.

J. Tate Thigpen of Jackson was recently appointed Associate Councilor for the State of Mississippi by the Southern Medical Association.

Stephen R. Thomas of Gulfport recently attended a course entitled *Current Trends in Total Hip Arthroplasty.*



FLIGHT SURGEONS WANTED.

Discover the thrill of flying, the end of paperwork and the enjoyment of a general practice as an Air Force flight surgeon. Take flight with today's Air Force and discover quality benefits, 30 days of vacation with pay each year and the support of a dedicated staff of professionals. Enjoy a true general practice on the ground, with the kind of stimulating challenge that will get your medical skills airborne. Talk to an Air Force medical program manager about becoming an Air Force flight surgeon. Call

USAF HEALTH PROFESSIONS
TOLL FREE 1-800-423-USAF

AIR FORCE

Personals/continued

Kazuo Ugajin has associated with the Meridian Neurosurgical Clinic, PA and **Roland T. Abangan** in the practice of Neurological Surgery.

E. Frazier Ward, III, an associate professor of orthopedic surgery at UMC recently received the 1991 Mary S. Baker award for outstanding professional and administrative leadership by the Mississippi Vocational and Rehabilitation Division. Dr. Ward has served as a consultant for the Vocational and Rehabilitation Services since 1965.

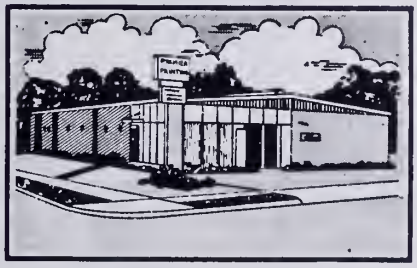
Thomas H. Weed has associated with **Robert H. Barnes** in the practice of general & thoracic surgery, Natchez, MS.

Eric Wyble of Gulfport was recently certified by the American Board of Plastic and Reconstructive Surgery.

John J. White of Jackson, recently lectured to the FLying Physician's Association at Martha's Vineyard, Mass., on *Lid Reconstruction Following Carcinoma Surgery.* ❑

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

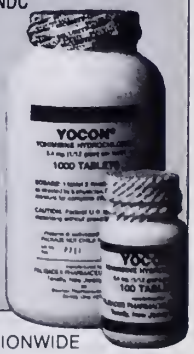
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720

Placement Service
Physicians Wanted

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Pascagoula Mississippi - Anesthesiologist Position Available for BC/BE Anesthesiologist. We administer all types of anesthesia including: open heart, cardiovascular, obstetrics, and general. Current compensation package competitive nationwide. Fringe Benefits include health, dental, life, long-term disablity, and malpractice insurance. Also included continuing education allowances, holidays and vacations. Local climate offers year-round recreation opportunities outdoors. Progressive city on Gulf, home to US Navy, many manufacturing facilities along with local seafood industries. Excellent school systems including division of University of Southern MS. Send CV to Pascagoula Anesthesia, Ltd. P.O. Box 1684, Pascagoula, MS 39568, (601)769-1021.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

Ophthalmologist Wanted for thriving, state-of-the-art eye practice in Columbus, Mississippi, seeking to add an associate leading to a partnership. Beautiful city of 25,000 with many varied recreational, social, and cultural activities. Competitive package. **Contact Albert Laws, M.D. at (601) 328-1254 or 2475 North 5th Street, Columbus, MD 39701.**

Emergency Medicine Opportunities -- Spectrum Emergency Care, the nation's largest provider of emergency department staffing and management services, currently has full and part-time staff physician opportunities at select client hospitals in Mississippi. As an independent contract physician, you will enjoy a variety of geographical locations in both large and small hospitals. Spectrum also offers participation in an occurrence-based malpractice insurance program, flexible scheduling, administrative support, and the opportunity for advancement. To learn more about the exciting opportunities currently available, **call Dan Fuller at 800/325-3982, ext. 7809.** Spectrum Emergency Care, 999 Executive Parkway, St. Louis, MO 63141.



Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

ORTHOPEDIC SURGERY - Louisiana - to be affiliated with highly regarded, well-established orthopedic surgeon. Supported by 212 - bed medical center providing a first year net guarantee between $200-250K based on experience. Additionally, office rent, business systems augmentation, a nurse, and on-line computer system will be provided at no cost to the first year physician. Finally, practice quality medicine and control your destiny from the inception. Excellent outdoor recreational opportunities. Contact Jim Wiederhold, Lowderman & Haney, Inc., 3939 Roswell Rd., NE, Suite 100, Marietta, GA 30062, (800) 486-3020 or use our fax (404) 977-6549.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119



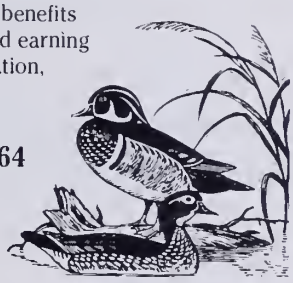
Orthopaedics

Outstanding opportunity for an Orthopaedic Surgeon to join a thriving practice in a community of 68,000 near Little Rock. Very busy orthopaedist affiliated with a large, state-of-the-art facility seeks an associate for his practice. Opportunity to practice general orthopaedics and develop subspecialty interests.

New orthopaedic offices, with over 3,300 square feet are located in the new medical tower adjoining the medical center and are equipped with the latest technology.

Good call coverage from other orthopaedists, as well as a good base of physicians for back-up and referrals.

Generous compensation and benefits package. Excellent growth and earning potential. For further information, contact:



Greg Foster
1 (800) 626-1857, ext. 264
Suite 250, Browenton Place
2000 Warrington Way
Louisville, KY 40222

SOUTHERN INDEPENDENCE

Large practice, small town. Established Family Medicine group in pre-revolutionary Pee Dee area community seeking physicians for a life-time commitment. New building, equipment, facilities, unequaled elsewhere. A truly special career opportunity in Family Medicine for a special physician. It don't get no better - friendly town with excellent quality of life. BC/BE only, please. $100,000+. Want more info? Contact:

Cheraw Family Medicine
Attention: C. Radkin
PO Box 867
Cheraw, South Carolina 29520
(803) 537-2171. Call collect.

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

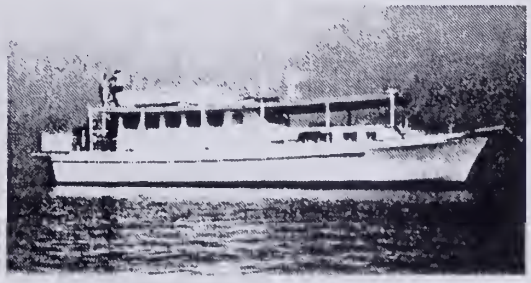
FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Family Practice/ ER Physician needed for fill-in coverage for CME, vacation, and Saturdays, 9:00 am to 6:00 pm. North East Jackson. Call 957-2273.

CHANDELEUR ISLAND FISHING

OMECO III

60' Twin Diesel
Air Conditioned
14' Fiberglass Skiffs
Outboard Motors
Oversized Bunks
All Meals Provided



Specializing in Trout and Redfish
601-432-2054 Biloxi, MS

Items for the Placement Service should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (404)421-4892

Or Fill Out Coupon and Mail Today!
To: SMSGT Hartung
14 AF/RSH
Dobbins AFB, GA 30069

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE

14-214-0011 A GREAT WAY TO SERVE

Classified

For Sale or Lease - Attractive office building 4200 sq. ft., 955 North State Street, Jackson, MS. One Block from Baptist Medical Center. Call (601) 948-1707.

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

FOR SALE: Tingle TXR 9 Radiographic unit. General practice with Flat Bucky table. Less than 2 years old. For more information call (601) 762-3664.

For Sale or Lease - Attractive office building in Jackson, on Highway 18 near Methodist Medical Center (formerly Hinds General Hospital). **8,000 sq. ft. available in suites and individual offices; newly carpeted and painted.** Ideal for Doctors or Medical Clinic. **Call 366-2478 or 354-3000.**

Index to Advertisers

CancerPay Plus 6

Deposit Guaranty Investments 8
Disability Determination 120
Doctors Insurance Reciprocal 86

Eli Lilly & Co. ..... 102 & 103

Employer Plus, Inc. 100

Harreld Chevrolet-Oldsmobile 113

Medical Assurance Co. of MS 106
Medley & Company 103
MS Emergency Association 119
MS Foundation for Medical Care 101
MS Methodist Rehabilitation Center .. **second cover**
MS Physicians Insurance Company ..... **third cover**
MS State Department of Health 95
MSMA Benefit Plan & Trust 112
MSMA Sponsored Insurance Plan 109

Palisades Pharmaceuticals 117
Physician Services of America 121
Premier Printing 117

Searle ..... **fourth cover**
St. Dominic's Hospital 99
St. Stanislaus 4

The Doctors' Company 118
Trustmark 107

US Air Force 116
US Air Force Reserve 122
US Army Reserve 108

Jon Wimbish 114

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings Up To 15 %
✔ 2. Established by Your Association	
✔ 3. Savings over what you currently are paying	
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association

LIBRARY

MAR 2 6 1992

ONCE DAILY 180mg Calan® SR verapamil HCl 180 mg
SUSTAINED-RELEASE CAPLETS

The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE *G.D. Searle & Co.*
Box 5110, Chicago, IL 60680

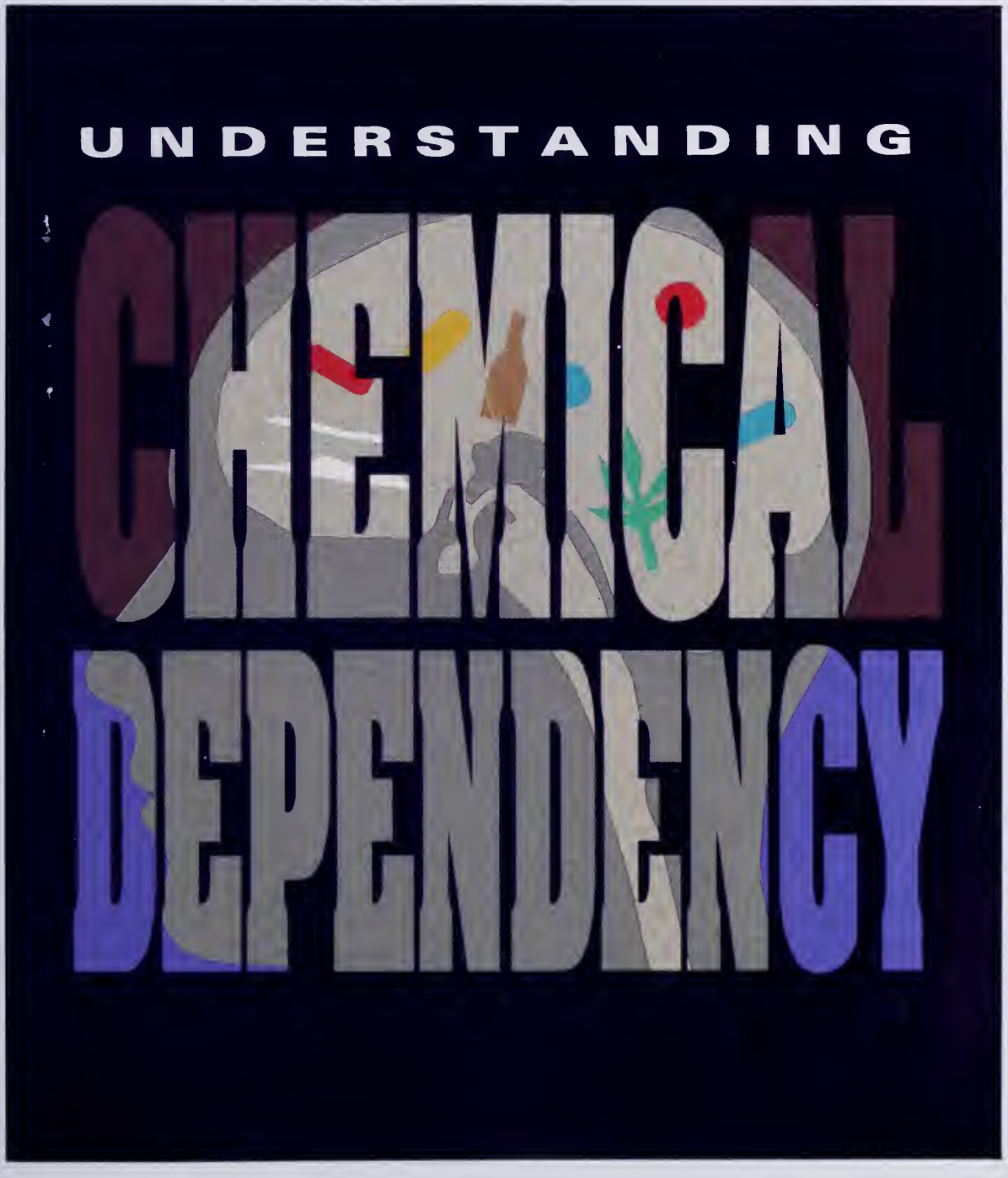
A91CA6148T



JOURNAL
OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

APRIL 1992

UNDERSTANDING CHEMICAL DEPENDENCY





"And I thought rehab was just a fancy name for therapy."



Dr. Karl Hatten doesn't work in rehabilitation, but he knows more about it than many so-called experts. He got his experience first-hand. As a nephrologist, he's spent more than 25 years helping patients deal with life-threatening diseases. But when he was hit by a stroke, he saw his own life hanging by a thread.

"Like many doctors, I had been confused by all the physical therapy programs that refer to themselves as rehab," he says. "My experience at MMRC taught me there's a big difference.

"The staff was incredibly supportive. They set realistic goals for my recovery, and helped me regain my self-confidence." In six months as a patient Dr. Hatten learned more about rehab than in 25 years as a doctor. Now he understands why MMRC is the South's leading rehabilitation center.

Today, he's back at work. With a fresh outlook on life. And a new perspective on rehabilitation.

Because when it's done right, rehab can do a lot more than repair a patient's body. It can even help a doctor see things more clearly.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

APRIL 1992 VOLUME XXXIII NUMBER 4

SCIENTIFIC ARTICLES

Understanding Chemical Dependence 123
H. Thomas Milhorn, Jr., MD, PhD

Ophthalmic Laser Surgery: Therapeutic Implications for the Primary Physician 131
MilamS. Cotten, MD

SPECIAL ARTICLE

Medicare Part B Reviews 138

EDITORIALS

Managed Care, or Manage Not to Care 140
James C. Waites, MD

Tribute 141
Myron W. Lockey, MD

Comment 141
W. Moncure Dabney, MD

DEPARTMENTS

124th Annual Session 148

Personals 156

Placement Service 161

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
James C. Waites, MD
President
William C. Gates, MD
President-Elect
Don Q. Mitchell, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings
✔ 2. Established by Your Association	Up To
✔ 3. Savings over what you currently are paying	15 %
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 4

April 1992

Dear Doctor:

The **MSMA 124th Annual Session will be held April 29 - May 3, 1992, at the Ramada Renaissance Hotel, Jackson, MS.** A schedule of meetings and other activities begins on page 148 of this issue of the *Journal MSMA*.

In Mississippi, the number of injury related deaths is higher than the national average in every age group. Motor vehicle accidents are the most common cause of death in every age group except those less than one year old.

Mississippi yearly ranks among the top three states in deaths due to motor vehicle accidents. In 1990, our state was second in the nation in motor vehicle deaths per 100,000 population.

Injury from trauma is the number one cause of death in the 1-44 year old age group, and accounts for more deaths in the 1-34 year old age group than all other diseases combined. Motor vehicle accidents caused the vast majority of these traumatic deaths, thus robbing our state of individuals in the most productive period of their lives.

For every person who dies from an injury, 15 others are hospitalized. This cost involves more than the direct cost of medical services. Rehabilitative services costs, time lost from jobs, and losses of productive output are staggering. The economic cost to our state from motor vehcile accidents alone is estimated at over one billion dollars per year.

The American Psychiatric Association will hold its 145th Annual Meeting, May 2-7, 1992 in Washington, DC. This year's session will address Humane Values and Biopsychosocial Integration. For further information contact: APA meetings management, (202) 682-6100.

The Ninety-Sixth Annual Meeting of The American Academy of Ophthalmology will be held Sunday, November 8 - Thursday, November 12, 1992 in Dallas, Texas. For further information contact: The American Academy of Ophthalmology, Meetings Department, PO Box 7424, San Francisco, CA 94120-7424, 415/561-8500.



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

The ACCUPRIL Single-Agent Commitment™

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.*†



New!

ONCE-A-DAY‡

ACCUPRIL®™

quinapril HCl tablets 10, 20, 40 mg

* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

© 1991 Warner-Lambert Company

PARKE-DAVIS

Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.



A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro chromosome* aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuance)	Placebo (N = 579) Incidence (Discontinuance)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, *heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances*

Gastrointestinal: dry mouth or throat, constipation, *gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests*

Nervous/Psychiatric: somnolence, vertigo, syncope, *nervousness, depression*

Integumentary: increased sweating, pruritus, *exfoliative dermatitis, photosensitivity reaction*

Urogenital: *acute renal failure*

Other: amblyopia, pharyngitis, sinusitis, bronchitis, *agranulocytosis, thrombocytopenia*

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

PD-103-JA-7164-A2(022)

THE UNITED STATES ARMY RESERVE
HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM
$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201

OR CALL COLLECT: (205) 930-9719 or 9727

CHARACTERISTICS OF DRUGS OF ABUSE

Drugs of abuse differ from other drugs by possessing a variety of characteristics: (1) They cause psychoactive effects; i.e., they produce such effects as euphoria, stimulation, and sedation. (2) Use of the drugs themselves reinforce their use. (3) Compulsive use occurs; i.e., the user feels compelled to continue using the drug. (4) Use continues despite adverse consequences. (5) Regular and temporal patterns of use occur. (6) Deprivation increases the desire to use the drug. (7) Paired stimuli increases the desire to use the drug; for instance, the sight of a cocaine pipe may trigger an overwhelming urge to use cocaine. (8) Tolerance develops; i.e., the more drug used over a period of time, the more is needed to get the same effect. (9) Physical dependence may develop; i.e., cessation of drug used may result in an abstinence syndrome (withdrawal signs and symptoms). And (10), the relapse rate is high.

ABSTINENCE SYNDROMES

At one point in time, it was felt that drugs could produce dependence only if they were capable of causing an abstinence syndrome on cessation of use. We now know this to be erroneous. Severity of acute abstinence syndromes for drugs of abuse range from life-threatening delirium tremens (CNS depressants) to the absolute lack of withdrawal signs and symptoms (hallucinogens) as shown in Table I. For most drugs of abuse, many of the minor signs and symptoms persist for weeks to months after the more dramatic ones of the acute abstinence syndromes are over. The prolonged abstinence syndrome is known as the **postacute abstinence syndrome**. The recovering addict is very vulnerable to relapse during this period of time.

Table 1- Severity of Acute Abstinence Syndromes

Drug group	Severity of Abstinence syndrome
depressants	++++
opioids	+++
stimulants	++
cannabinoids	++
phencyclidines	++
inhalants	+
anabolic steroids	+
hallucinogens	-

HOW DRUGS AFFECT THE BRAIN

To understand how drugs exert their influence on the brain, it is first necessary to understand the functions of the limbic system and the synapse.

The Limbic System

All drugs of abuse act in the brain to change the way one feels. That is why they are called psychoactive substances. It is the feelings produced by drugs that users seek. People, then, get addicted to feelings, not drugs. The cocaine addict, for example, would be just as happy getting the "high" from stimulation of an electrode placed in the pleasure center of his or her brain as from doses of cocaine.

The part of the brain that is responsible for feelings is called the limbic system. This is where drugs of abuse produce their effects. The limbic system is located deep within the brain. The hypothalamus, which contains the pleasure center of the brain, is part of the limbic system.

Drugs, as we will see, produce feelings by altering the functioning of chemicals in the limbic system called neurotransmitters.

The Synapse

Drugs exert their effects primarily by altering the functioning of synapses in the brain. To understand the effects of drugs, it is necessary, therefore, to understand the synapse and how it normally functions (see Figure 1). As action potentials move along the presynaptic neuron, they reach the nerve terminal where they cause the release of calcium ions. These, in turn, act on storage vesicles to cause the release of specific neurotransmitter molecules. The neurotransmitter molecules then cross the synaptic cleft where they briefly interact with receptors on the postsynaptic neuron. Activation of the receptors causes the conversion of adenyl cyclase to cyclic AMP which in turn initiates action potentials in the postsynaptic neuron. After the brief interaction with the receptors, the neurotransmitter molecules tend to return to the presynaptic vesicles for storage and reuse. However, a portion of the neurotransmitter molecules are inactivated by an enzyme in the synaptic cleft.

Effects of Drugs on Synaptic Function

Drugs can alter synaptic function by a variety of

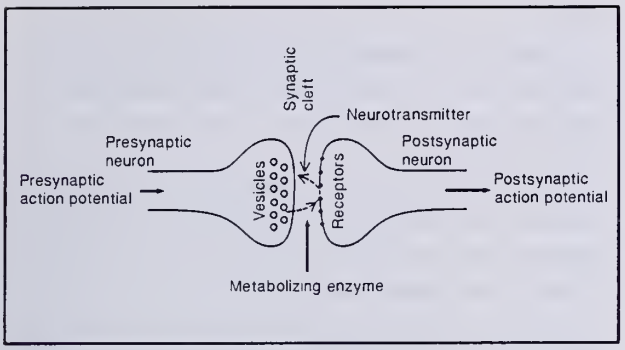


Figure 1 - Synaptic Transmission

mechanisms. A drug may mimic the activity of a neurotransmitter by interacting with the postsynaptic receptors, block the interaction of the neurotransmitter with its postsynaptic receptors, or act in a way that alters the neurotransmitter concentration in the synaptic cleft. All three mechanisms alter synaptic transmission of nerve signals. A drug can increase synaptic cleft neurotransmitter concentration by blocking the reuptake of the neurotransmitter by the presynaptic vesicles or by facilitating release of the neurotransmitter from the presynaptic vesicles.

The Neurotransmitters

Six neurotransmitters (gamma-aminobutyric acid, acetylcholine, norepinephrine, dopamine, serotonin, beta-endorphin) account for most of the effects produced by the action of drugs of abuse on the brain.

Gama-aminobutyric acid (GABA). Unlike other neurotransmitters, GABA acts in the brain to inhibit synaptic transmission. Drugs that exert their effects through the GABA neurotransmitter system include all the depressants. Phencyclidine has an effect on all six neurotransmitters, including GABA.

Acetylcholine. This neurotransmitter counterbalances the effects of dopamine and functions in initiating short term memory as well as maintaining memory. Phencyclidine and nicotine influence the acetylcholine neurotransmitter system.

Norepinephrine. This neurotransmitter is responsible for modulating mood and maintaining sleep states. It is affected primarily by the stimulant drugs and also by phencyclidine and the opioid drugs.

Dopamine. This neurotransmitter serves to counterbalance the effects of acetylcholine. In addition, it stimulates the pleasure center, modulates mood, affects intellectual processes, and inhibits prolactin release. Prolactin is a hormone involved in milk production in nursing mothers. Dopamine is affected by the stimulant drugs, as well as phencyclidine.

Serotonin. This neurotransmitter is involved in modulating mood, initiating sleep and rapid eye movement (REM) sleep which is the portion of sleep in which dreams occur. It is affected by the hallucinogenic group of drugs and phencyclidine

Beta-endorphin. This neurotransmitter is involved in modulating mood and in pain perception. It also inhibits norepinephrine release. It is affected by the opioid group of drugs, as well as phencyclidine.

The neurotransmitters responsible for the effects of marijuana and anabolic steroids have not yet been identified.

Example of Synaptic Function Alteration

As an example of how a drug of abuse can cause psychoactive effects, let us consider cocaine. Evidence suggests that the major psychoactive effects of cocaine result from altered synaptic dopamine concentration in the hypothalamus which contains the pleasure center of the brain. Normally, action potentials travel down the presynaptic neuron to the nerve terminal where they cause release of dopamine from presynaptic vesicles. The dopamine then crosses the synaptic cleft to simulate receptors on the postsynaptic neuron and, thereby, initiate secondary action potentials which proceed down the postsynaptic neuron. Most of the dopamine is then taken back up by the presynaptic vesicles for reuse. Some of it, however, is metabolized by an enzyme, catechol-o-methyltransferase, in the synaptic cleft. With acute use, blockage of dopamine reuptake by cocaine increases the dopamine concentration in the synaptic cleft thus enhancing synaptic transmission (see Figure 2A). Repeated cocaine use tends to decrease synaptic transmission by depleting dopamine stores in the presynaptic vesicles because the portion that is normally reused in metabolized by catechol-O-methyltransferase (see Figure 2B).

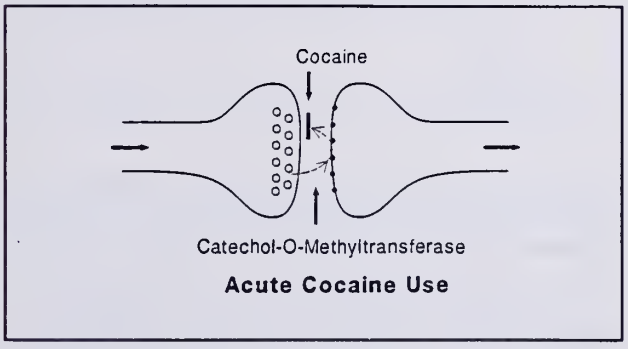


Figure 2 A- Effect of acute cocaine use on synaptic transmission.

It is hypothesized that the euphoria of acute co-

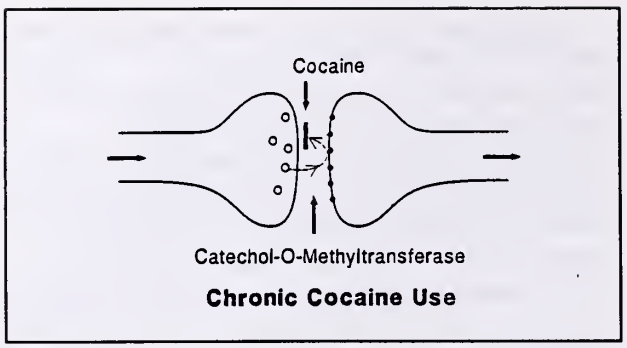


Figure 2 B - Effect of chronic cocaine use on synaptic transmission.

caine use results from the transiently increased synaptic dopamine concentration, and resultant increased synaptic transmission. The dysphoria that results from chronic cocaine use is felt to be due to depressed baseline synaptic dopamine concentration, and depressed synaptic transmission (see Figure 3). Repeated use of the drug in an attempt to achieve the original euphoria fails to do so. In fact, use may only result in a brief period of relief from the dysphoria; i.e., just feeling normal.

Cocaine also blocks reuptake of two other neurotransmitters - norepinephrine and serotonin. The role this plays in cocaine dependence is uncertain.

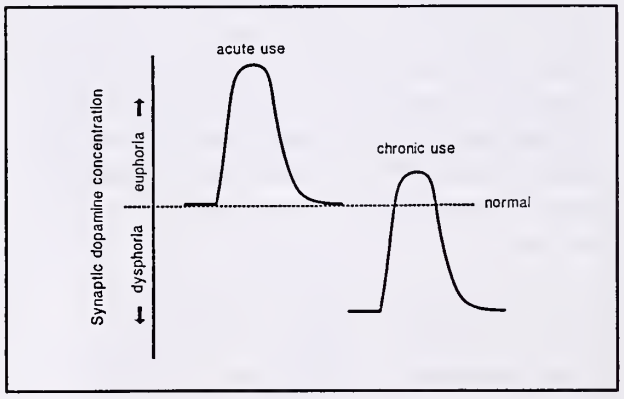


Figure 3 - Effect of acute and chronic cocaine use on synaptic dopamine.

PRIMITIVE SURVIVAL-BRAIN CONCEPT

The primitive survival-brain concept of chemical dependence is based on the premise that millions of years ago on the evolutionary tree, man did not possess a reasoning, thinking brain (the cerebral cortex) but instead depended entirely on a rudimentary brain whose single minded purpose was survival. This primitive brain served to find food and water, flee or fight when the occasion arose, and to have sex for survival of the species. The limbic system is part of this primitive brain. It is composed of, among other things, the hypothalamus, the amygdala, and the septum. The hypothalamus is where many drugs exert their psychoactive effects.

Chemical dependence is thought of as being a reversion from thinking and reasoning to survival of the individual (see Figure 4). During the use and abuse phases, the cerebral cortex is in charge. One may say, having processed the thought in his or her cerebral cortex, "I think I'll use some cocaine." Once chemical dependence has developed, the cerebral cortex is no longer in charge, and the primitive survival-brain sends the message, "If I don't get some cocaine, I'm going to die." Getting cocaine has become a matter of survival, thus explaining why one addicted to cocaine will lie, cheat, steal, and prostitute to get the drug when he or she otherwise would not do such things. The movement of control from the cerebral cortex to the primitive survival-brain is thought to be due to neurotransmitter derangement in the hypothalamus.

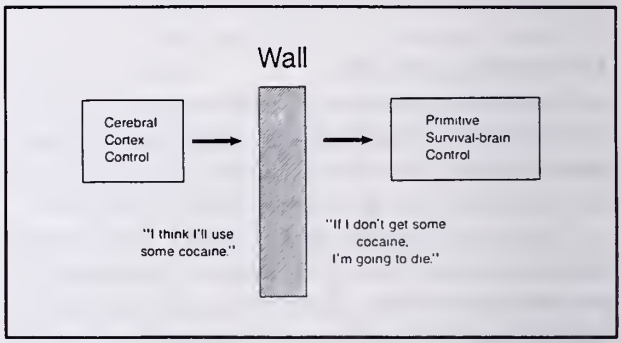


Figure 4 - Primitive survival-brain concept of chemical dependence.

Movement of control from the cerebral cortex to the primitive survival-brain is analogous to the concept of "crossing the wall" as illustrated in Figure 4. According to this concept he movement from use of abuse to dependence is like crossing a wall - once it occurs, it is extremely difficult, without help, to get back on the other side of the wall; i.e., to again become nondependent.

DENIAL

Denial, the major symptom of chemical dependence, is most simply defined as not recognizing a problem, even in the face of significant adverse consequences and despite the fact that the problem is

evident to others. It can be explained by an interplay between the limbic system and the cerebral cortex. In the use and abuse phases, drugs act on the limbic system (see Figure 5) to produce drug craving. The drug craving then acts on the cerebral cortex to produce addictive behaviors (lying, stealing, cheating, and prostituting) to get the drugs. These behaviors, in return, produce guilt. The guilt then serves to reduce the drug use as shown by the dashed line. Once dependence develops, however, the drug craving is so intense that guilt is no longer able to reduce the drug use. Drug use continues despite the addictive behaviors and the problems they cause. Denial develops to protect the mind from the psychological pain of the internal conflict between uncontrollable drug use and guilt.

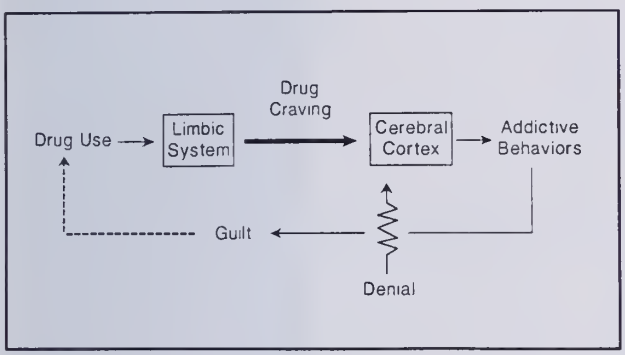


Figure 5 - Mechanism of denial.

Chemically dependent individuals use a variety of tools to achieve denial: (1) rationalization - using socially acceptable but untrue explanations for inappropriate behavior; (2) projection -blaming others for one's own failings and inadequacies; (3) minimization - underestimating the magnitude of one's drug use; (4) repression - unconsciously excluding from one's conscious mind unbearable thoughts, experiences, or feelings; (5) suppression - consciously pushing away feelings and events into the background; (6) isolation - deliberately avoiding relationships and communication with others that might threaten the ability to use a drug; (7) regression - reverting to a level of emotional maturity appropriate to an earlier stage in life; and (8) conversion - expressing emotional conflict through physical symptoms. This last tool allows addicts to focus on minor physical symptoms so as to avoid dealing with the underlying cause of them, which is chemical dependence.

Denial is not specific to the drug addict. It occurs in other circumstances as well. For example, it is the first stage of the grief process (denial --> anger --> bargaining --> depression --> acceptance). To protect the mind from the overwhelming grief that would occur from the death of a spouse or child, denial moderates the effect.

DISEASE MODEL OF CHEMICAL DEPENDENCE

There is a growing consensus that chemical dependence is a disease; i.e., it is pathological state with characteristic signs and symptoms and a predictable course and outcome if untreated. It is considered to involve an interplay among biological, psychological, and social factors. Thus, chemical dependence is considered to be a biopsychosocial disease. The biological component involves both a genetic disposition in many individuals (at least for alcoholism) and the medical complications that result from drug use. Psychological consequences of drug use include depression, paranoia, anxiety, insomnia, panic attacks, personality alteration, and psychosis. Social factors resulting from drug use include family problems, problems with friends, job problems, and problems, with legal authorities, such as driving under the influence (DUI) or arrests for drunk and disorderly conduct, drug possession, or intent to sell.

The disease model allows treatment professionals to use familiar techniques to make a diagnosis, form a treatment plan, educate a patient, and discuss prognosis. It helps differentiate chemical dependence from a bad habit, moral weakness, or lack of willpower. It obligates treatment professionals to address chemical dependence in a nonjudgemental manner.

DEFINITION OF CHEMICAL DEPENDENCE

A number of definitions of chemical dependence exist. The one I have found to be most helpful is based on a description of alcoholism (alcohol dependence) as an illness by the American Medical Association (AMA) in 1956. The AMA extended this description to all drugs of abuse in 1987. Based on the AMA's description, we arrived at the following definition - Chemical dependence is a chronic, progressive disease characterized by significant impairment that is directly associated with persistent and excessive use of a psychoactive substance. Impairment may involve physiological, psychological, or social dysfunction.

This definition implicitly states several things: (1) Chemical dependence is a disease. (2) It is chronic;

i.e., it takes place over a period of months to years. (3) It is progressive; i.e., it gets worse over time if not treated. And (4) it causes significant impairment from physiological dysfunction (medical problems), psychological dysfunction, or social dysfunction. The impairment must be directly related to persistent and excessive use of a psychoactive substance.

However, the definition does not address several things: (1) Persistent is not defined. Drug use every weekend is certainly persistent, and can cause significant dysfunction. A person, therefore, does not have to use drugs on a daily basis to be dependent. (2) Excessive is also not defined. It suggests a quantity of a psychoactive substance that, when used in a persistent fashion, is sufficient to cause significant impairment in one of the three major areas of life given in the definition. And (3), users may suffer withdrawal symptoms with cessation of drug use, but such symptoms are not required for the diagnosis of chemical dependence. ❑

Laurel Wood Center
Highway 39 North
Meridian, MS 39303

REFERENCES

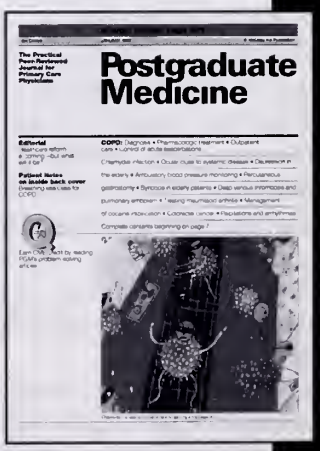
1. Cohen S. *The Chemical Brain: Neurochemistry of Addictive Disorders.* Care Institute, Irvine, CA, 1988.
2. Dackis CA, Gold MS. Psychopharmacology of cocaine. *Psychiatric Annals,* 1988;18:528-530.
3. Giannini AJ, Miller NS. Drug Abuse: A Biopsychiatric Model. *American Family Physician,* 1989;40:173-182.
4. Milhorn HT, Jr. Chemical Dependence: Diagnosis, Treatment, and Prevention. Springer-Verlag, New York, 1990.
5. Milhorn HT, Jr. The Diagnosis of Alcoholism. *American Family Physician,* 1988;37:175-183.
6. Milhorn HT, Jr. Nicotine Dependence. *American Family Physician,* 1989;39:214-224.
7. Milhorn HT, Jr. Screening, Assessment, and Diagnosis. *In Review Course Syllabus,* American Society of Addiction Medicine, New York, 1990.
8. Schuckit MA. Genetics and the risk of alcoholism. *Journal of the American Medical Association,* 1988;254:2614-2517.
9. Van Cleave S, Byrd W and Revell K. *Counselling for Substance Abuse and Addiction.* Word Book, Waco, TX., 1987.
10. Wyatt RJ, Karourn F, Saddath R, and Hitri A. The role of dopamine in cocaine use and abuse. *Psychiatric Annals,* 1988;18:531-534.

***Dr. Milhorn** is professor, Department of Family Medicine: Professor, Department of Physiology and Biophysics; and Associate Professor, Department of Psychiatry and Human Behavior at the University of Mississippi School of Medicine.*

US THEM



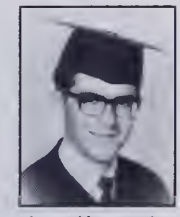




WHEN YOU NEED TIME ON YOUR SIDE, THE CHOICE IS CLEAR.

NO CLINICAL CLUTTER— PGM ARTICLES ARE CLEAR, CONCISE, WELL ILLUSTRATED, AND PRACTICAL.

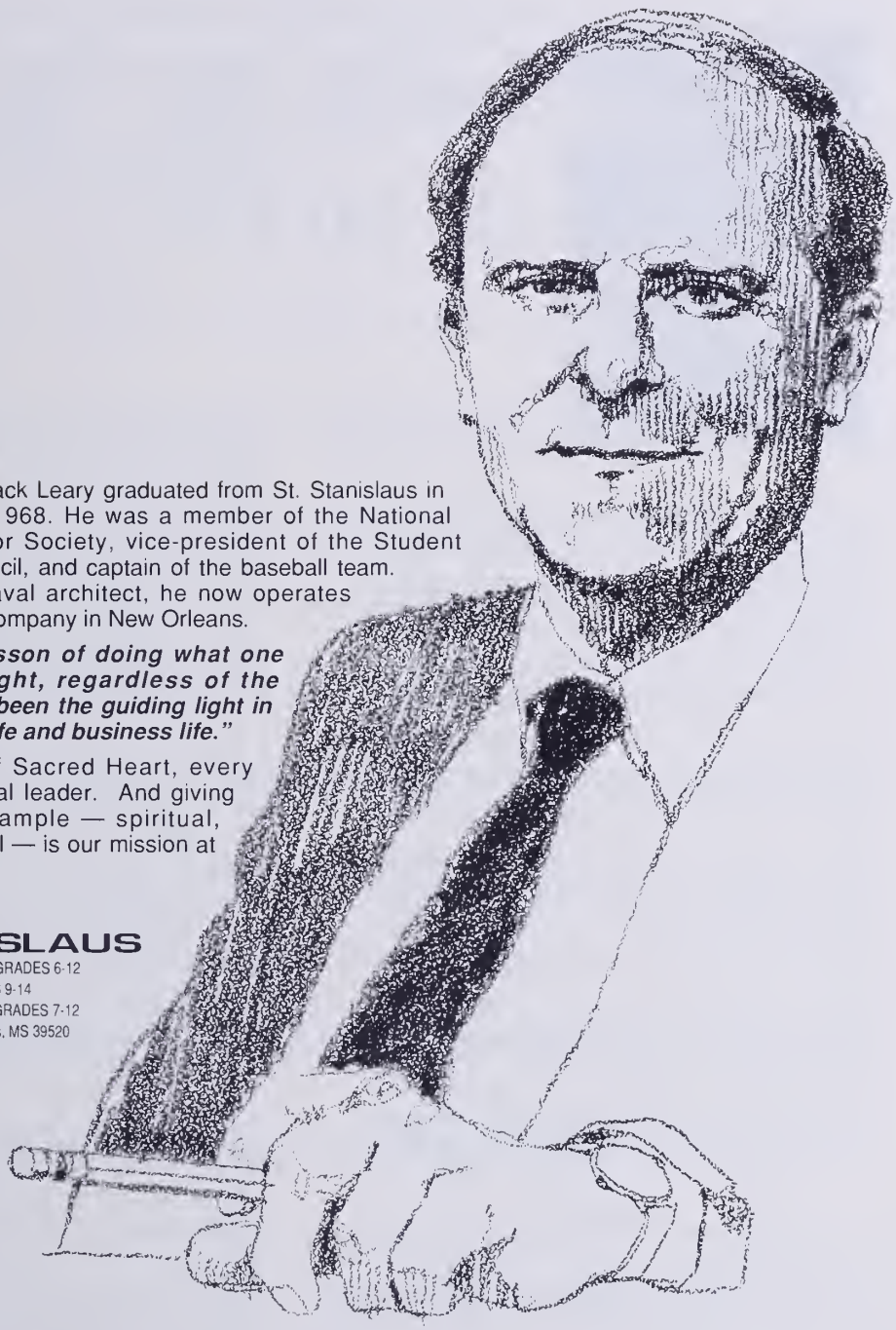
Postgraduate Medicine PGM



Jack Leary graduated from St. Stanislaus in 1968. He was a member of the National Honor Society, vice-president of the Student Council, and captain of the baseball team. A self-employed naval architect, he now operates Leary Engineering Company in New Orleans.

"The Brothers' lesson of doing what one believes to be right, regardless of the consequence, has been the guiding light in both my personal life and business life."

To the Brothers of Sacred Heart, every student is a potential leader. And giving him the proper example — spiritual, intellectual and moral — is our mission at St. Stanislaus.



SAINT STANISLAUS
BOARDING SCHOOL GRADES 6-12
SUMMER CAMP AGES 9-14
OPENINGS FOR DAY STUDENTS GRADES 7-12
304 South Beach Blvd. Bay St. Louis, MS 39520

FOR A FREE BROCHURE CALL THE DIRECTOR OF ADMISSIONS — (601) 467-9057

St. Stanislaus helps build leaders.



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

Ophthalmic Laser Surgery: Therapeutic Implications for the Primary Physician

Milam S. Cotten, MD

Early detection and treatment of eye disorders can make the difference between night and day - blindness and sight - for patients who might otherwise risk significant impairment or loss of their vision without timely treatment early in the progression of disease.[1-3] Non-ophthalmologists can play a vital role by suspecting vision problems in patients with medical conditions that often result in ophthalmic diseases, and then referring those patients to an ophthalmologist.

This paper represents the results of a retrospective study on the diagnosis and treatment of 102 consecutive patients who received laser surgery in a general ophthalmic practice. The purpose of the study is to document and interpret the six types of eye disorders that lend themselves to definitive laser treatment. The goal of this article is to enhance the awareness of non-ophthalmologists in their pivotal and vital role in referring patients to an ophthalmologist for evaluation of the basic disease processes which, left untreated, can lead to vision impairment or blindness.

This paper represents the results of a retrospective study on the diagnosis and treatment of 102 consecutive patients who received laser surgery in a general ophthalmic practice during the period of August 1989 to September 1991. The purpose of the study is to document and interpret the type of eye disorders that lend themselves to definitive laser treatment. The goal of this article is to enhance the awareness of non-ophthalmologists in their pivotal and vital role in referring patients to an ophthalmologist for evaluation of the basic disease processes which, left untreated, can lead to vision impairment or blindness.

Scope

This article is not intended to be a review of the literature regarding the subjects addressed. However, basic references are included to enhance credibility and provide a baseline for literature searches.[4] The socio-economic impacts of the diseases described here are beyond the intent of this article, but are of absolute, paramount importance and are addressed in some of the referenced materials.

Detailed chart data is presented in seven graphs. Photographs demonstrating usage of the YAG and Argon laser machines are also included.

Aging: A Common Denominator

Diseases treated in medical offices daily include diabetes mellitus, hypertension and other disorders generally associated with aging that are at high risk for producing significant visual disability. Aging is the one common denominator in the eye diseases that are documented in this paper. Summation of the vascular and glaucomatous conditions reviewed indicate that 53 percent of the patients in the series are being seen primarily by non-ophthalmologists for their basic disease process. Primary care physicians are therefore in the position to determine the state of the patients' ocular status and to insure that people who are at

risk are referred for appropriate eye examinations.

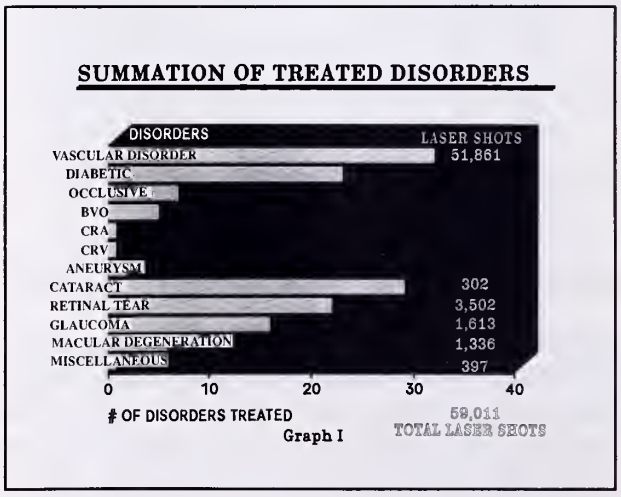
Suspect Eye Complications

Increased awareness by primary care physicians of eye complications and the appropriate response in the referral of patients with eye disorders that are best treated by lasers can be of vital benefit to existing and potential patients. Eyesight can be saved through early referrals.

When patients have cataracts, failing vision, vitreal floaters (black specks floating in the field of vision) or eye lash irritation, most will seek care from an ophthalmologist. But for other conditions such as hypertension or diabetes mellitus that can result in eye disorders, patients are not as likely to seek help from an ophthalmologist. In these cases the primary care physician can save patients' sight by referring them for ophthalmic evaluation and treatment.

Type I and II diabetics should have baseline ophthalmological evaluations and followups as appropriate. Hypertensive patients also need a baseline evaluation and periodic eye exams by their primary physicians with ophthalmic referrals if visual problems develop or retinal changes occur. A diagnosis of glaucoma can be suspected from family history, decreasing vision and optic disk evaluation plus tonometry. Appropriate ophthalmic referral should be made.

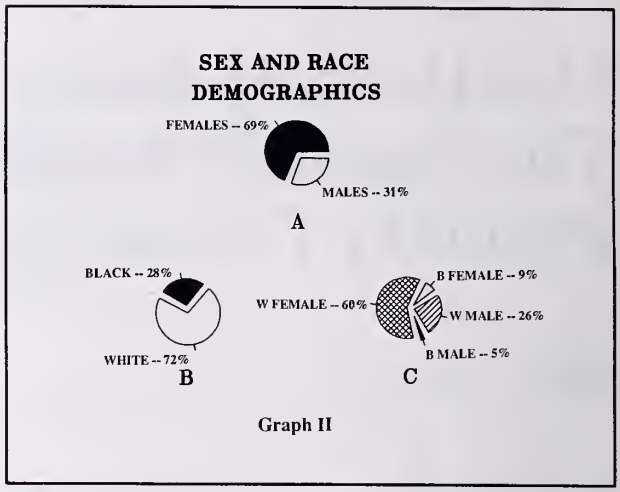
SIX BASIC DISORDERS APPLICABLE TO LASER TREATMENT



Graph I

Vascular Disorders

Vascular disorders represent 32 percent of the treated disorders and include diabetic-related conditions and disorders of the retinal vessels including central retinal artery and central retinal vein occlusions, plus branch vein occlusions and retinal aneurysms.



Graph II

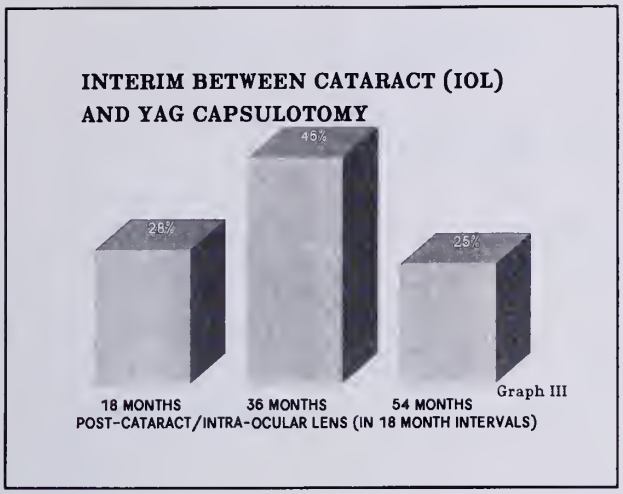
In vascular disorders I advise patients prior to laser surgery that it is important to realize that success is measured in several ways. For diabetics it is important to attempt to restore vision as best as possible. However, success is also measured in terms of maintaining vision currently enjoyed, and in preventing it from getting worse. This is particularly important in the case of vascular disorders, occlusions, retinal aneurysms and age-related macular degeneration.

Cataract Related Laser Surgery

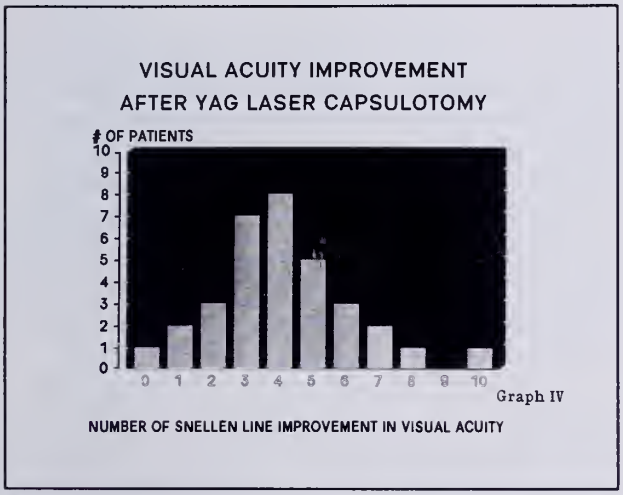


YAG laser used for cataract related surgery . (demonstration photo)

The second category is cataract related and represents 29 percent of the patients in this series. It is important to note that primary cataracts cannot be treated with lasers; they require open surgery to remove the cataract and place an implant in the eye. Lasers are useful for after-cataract membrane capsulotomy[5] required if the posterior capsule membrane thickens and becomes less transparent. This occurs in certain patients several months after cataract-intraocular lens implantation.



Graph III



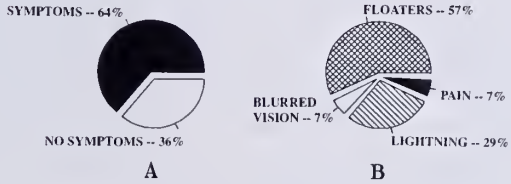
Graph IV



Argon Laser used for non-cataract related surgery. (demonstration photo)

Retinal Tears

The third category, retinal tears, [6,7] represents 22 percent of the patients and is associated with various signs and symptoms such as vitreal floaters, lightning flashes, pain and blurred vision. Also, some patients had retinal tears without showing the symptoms and were discovered by a dilated eye exam. It is important to note that all of the retinal tears were treated successfully, which prevented retinal detachments and possible blindness. Several cases had to have repeat laser treatment to insure that an adequate sealing of the retinal tear had been accomplished.



Graph V

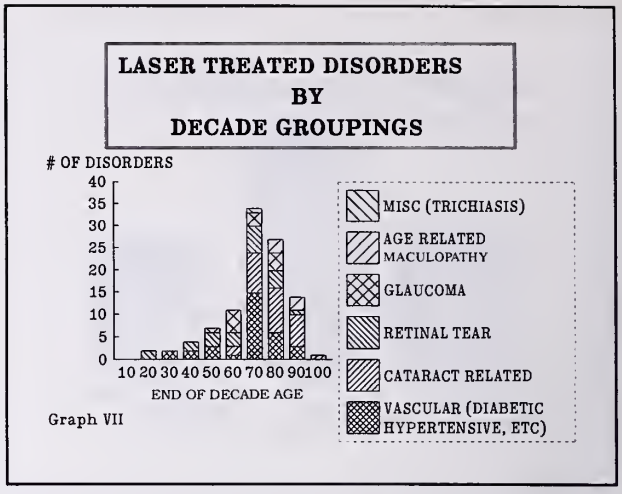
Glaucoma-Related Conditions

The fourth category represents glaucoma related conditions,[8] and represents 16 percent of the patients. Included in this series are three angle-closure glaucomas that were iatrogenically produced by the instillation of dilating drops in physician's offices. This emphasizes the importance of being aware of this condition and how to treat it appropriately. The remainder of the glaucoma cases represent chronic simple open-angle glaucoma related in some way to aging (all patients in this series were over the age of 40). There were also several cases of secondary glaucoma resulting from a previous eye injury.

In the case of glaucoma, the ideal result is the reduction of pressure to normal ranges without the need for either a systemic medication or local anti-glaucomatous drops to control a portion of the glaucoma. In cases of the true acute angle-closure glaucoma, the control of excessive pressure, pain and other problems was accomplished with laser surgery although some of the patients still had to use drops, particularly if they had elements of open-angle or narrow-angle glaucoma.

A Silent Disorder

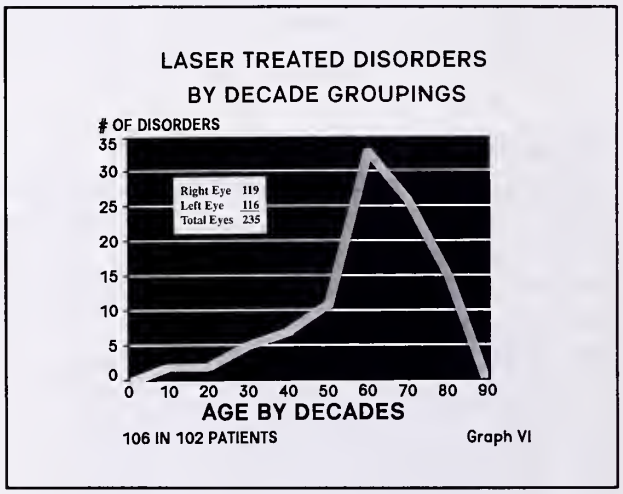
The fifth category is macular degeneration which, with the current medical terminology, is defined as age-related macular degeneration[2] and represents six percent of the patients. The importance of immediate referral for persons developing central scotoma (blind spot in visual field) is emphasized in this type of patient since this is a silent disorder usually found in older people with systemic hypertension. Patients at risk for maculopathy should be advised of the importance of checking their vision on a normal vision target, such as a television monitor number or an Amsler grid, and the importance of seeking immediate attention if vision decreases.



Graph VII

Miscellaneous

The last category is miscellaneous: trichiasis (misdirected eyelashes) was seen in one patient. Trichiasis is a frequent complaint of the elderly and can be handled effectively at times just by the removal of misdirected lashes. However, it is frequently necessary to direct attention to the lid itself and use the laser to ablate lash follicles.[9]



Graph VI

Laser Surgery Benefits

When recommending laser surgery for a patient, the primary care physician can reassure the patient by explaining that laser surgery is non-invasive, safe, produces very few complications, generally requires only local eye drop anesthesia and allows rapid recovery. Laser surgery is also cost effective because it is normally done on an out-patient basis and results in little lost time at work because of the quick recovery time. No patient is this series suffered any visual loss from the laser treatment.

Lasers are also an advantage because they are used where no previous treatment was available and for procedures that previously required invasive surgery. The results are rapid and long-lasting, yet can be repeated if necessary because of the disease process.

Frequently multiple patients are treated at the same time to promote "group acceptance" of laser treatment; patients feel reassured if they are with others undergoing the same treatment.

Summary

The most critical fact uncovered by this review is that more than half of the subjects had laser surgery as a result of diseases that would be treated primarily by a physician other than an ophthalmologist. Primary care physicians can play an extremely important function directing these patients to an ophthalmologist for laser surgery that can save their eyesight. ❑

710 South 28th Avenue
Hattiesburg, Mississippi 39402-2524

Acknowledgements

The author thanks LaNell Daniels, doctoral candidate at the University of Southern Mississippi, for help developing the review and Cheryl Cain of Methodist Hospital for assistance with graphics. The author also acknowledges his staff for special efforts in compiling the data, and free-lance writer Becky Gillette for editing assistance.

References

1. Lichter PR, Sugar A. Results from the Early Treatment of Diabetic Retinopathy Study. *Ophthalmology*, Supplement

1991;98:741-840.
2. Gitter KA, Schatz H, Yannuzzi LA, et.al. Laser Photocoagulation of Retinal Disease, ed 1, Schaeffer D, San Francisco, Pacific Medical Press, 1988, pp 75-87.
3. Blankenship GW. Fifteen-year Argon Laser and Xenon Photocoagulation Results of Bascom Palmer Eye Institute's Patients Participating in the Diabetic Retinopathy Study. *Ophthalmology* 1991;98:125-128.
4 Javitt JC, Aiello LP, Bassi LJ, et.al. Detecting and Treating Retinopathy in Patients with Type I Diabetes Mellitus. *Ophthalmology* 1991;98:1565-1574.
5. Aron-Rosa DS, Gaasterland DE, Boileau-Bonnet CM, et. al. Pulsed YAG Laser Surgery, ed 1, Aron-Rosa DS, Thorofare, New Jersey, Slack, Inc., 1983, pp 3-148.
6. Sweng CH, Little HL, Vassiliadis A. Argon Laser Photocoagulation. ed 1, Saint Louis, CV Mosby Co., 1977, pp 25-41.
7. Swiddy WE, Flynn HW, Nicholson DH, et.al. Results and Complications in Treated Retinal Breaks. *Amer. J Ophthalmology* 1991;122:623-631.
8. Wise JB, Whitter SL. Argon Laser Therapy For Open-Angle Glaucoma: A Pilot Study. *Arch Ophthalmol* 1979;97:319-322.
9. Awan KJ. Argon Laser Treatment of Trichiasis. *Ophthalmic Surg* 1986;17:658-660.

Dr. Cotten is an ophthalmologist in private practice at 710 South 28th Avenue, Hattiesburg, MS. He is on staff at Forrest General Hospital and Methodist Hospital. He has also participated in Rotary Club medical/surgical missions in Africa and South America.

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

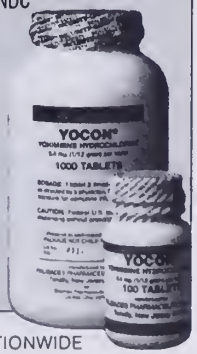
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216



Partners In Health Care

Mississippi physicians and the public health system work together as partners. In December, we told you why and how. In January, we recognized private physicians who "partner" through contractual arrangements with the Department of Health, and in February we listed some of the physicians who've chosen full-time, permanent positions with the public health team.

This month we introduce you to the physicians who serve in the county health departments and public health districts: Mary-Gayle Armstrong, Hinds County; Federico Arana, Southeast District VIII; Mary Ellen Bouldin, Coahoma County; Lovetta A. Brown, Grenada County; Cathy Ann Butts, Coastal Plains District IX; Fe N. Cabanero, Sunflower County; Rebecca L. Clemmons, Lauderdale County; Monica Joan Collins, Hinds County; Cecil B. Ferguson, III, Hinds County; Ralph Doyle Ford, Tippah County; Dexter Hongwing Guon, Lafayette County; Delores E. Hatcher, Lauderdale County; Arvis L. Hawkins, Washington County; Michael F. Hensley, Coastal Plains District IX; Cecil G. Jenkins, Hinds County; Lynda G. Lee, Southwest District VII; Michael L. Palmer, Hinds County; Alberto Sandino, Adams County; Danilo P. Santiago, Lauderdale County; Charles C. Sledge, Hinds County; Martha L. Stevens, Southeast District VIII; Teresa A. Williamson, Delta Hills District III; and Bobby Joe Wolfe, Jr., Rankin County.

We must continue to work together. Together, we can!

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

Special Article

Medicare Part B Reviews

If you would like to reduce the number of claims that are appealed on the review level and in cases where reviews are requested make the process easier, continue reading this article. While this article is not intended to cover all aspects of the review process, it will cover some major requirements that need to be reemphasized, followed by some key suggestions to use in eliminating and requesting reviews.

MAJOR REQUIREMENTS

1. The review must be requested within six months of the date on the initial notice of determination.

2. The request must be in writing and signed.

3. The request must clearly state that a review is being requested and identify the services at issue. A copy of the initial notice with various items highlighted or a copy of a claim with notations such as "second request or resubmit" does not qualify as a review request. In fact, such notations are very confusing since they do not describe a specific problem or request a specific action by the Medicare carrier. Non-specific correspondence will be returned for clarification. A notation on the copy to review or reconsider a specific service would qualify as a review, provided it is properly signed. A request to reopen is also treated as a request to review.

4. Any supporting documentation must be submitted with the review request. Medicare will not develop it in assigned cases.

5. A physician or supplier cannot request a review on a non-assigned claim unless it was denied for medical necessity or reasonableness.

REDUCING THE NUMBER OF REVIEW REQUESTS

Use the following suggestions to reduce the number of reviews requested, and related expenses. These suggestions apply when filing the initial claim.

1. Respond to request for information promptly to avoid claim denials.

2. Read all Medicare Newsletters and Bulletins to keep up to date on new billing requirements. Share them with all office staff.

As a general note, most of the claims that are paid at the initial review level are allowed as a result of receiving additional information along with the review request. Had the information been sent with the original claim, the review would have been avoided. (i.e. in the first quarter of 1991 over 60% were paid at the initial review level)

If a claim is denied for missing or incomplete information, it is not always necessary to file a review request. The denied claim or service can be filed as a new claim with the required information. Unlike a review request, once the claims are filed as new, they are subject to the processing timeliness and interest payment requirements for claims.

FILING THE REVIEW REQUEST

Please use the following suggestions when filing your requests. These suggestions are in addition to an complement the requirements stated above.

1. Specifically identify the beneficiary and service(s) involved. A copy of the Provider Summary and/or

claim included with your request is the preferred method. If you use this method, remember to specifically request a review.

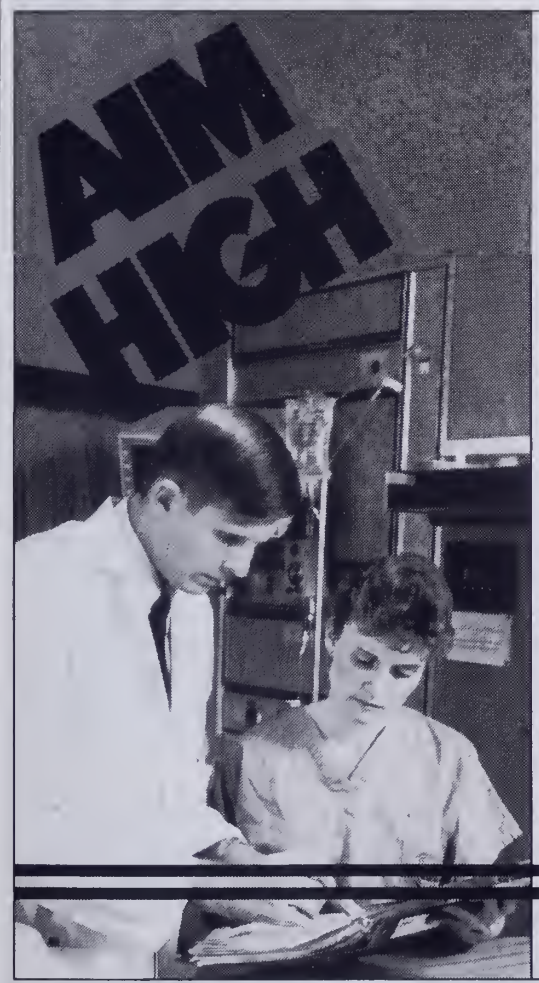
2. If you do not use the method in 1 above, be sure to include the beneficiary's name, claim number, control number, date and description of the service in question.

3. Include a brief description of the problem or complaint.

4. You are entitled to one review of a claim, therefore, include any additional information or documentation that you feel will have a bearing on the review decision. Documentation regarding medical necessity must be accurate and supported by information in the patient's medical record. Inaccurate documentation for the purpose of obtaining Medicare reimbursement is considered to be Medicare program abuse.

5. Be sure to review the denial message carefully prior to requesting the review to ensure that required information is submitted with the review request. For example, claim is denied because it contained no ICD-9 diagnosis code, and when the review request is received it includes information that there was no purchased services on the claim.

Again, this article reemphasizes some of the major points in the review process. It is not intended to cover all aspects of appeals. ❑



BE AN AIR FORCE PHYSICIAN.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle and benefits you enjoy as an Air Force professional, along with:

- 30 days vacation with pay per year
- Dedicated, professional staff
- Non-contributing retirement plan if qualified

Today's Air Force offers the medical environment you seek. Find out how to qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE 1-800-423-USAF

AIR FORCE



The President's Page

JAMES C. WAITES, MD

Managed Care, or Manage Not To Care

As I am writing this, I have just finished reading several articles in our local paper that dealt with the practice of medicine. One of these articles, written by a physician, Dr. W. Gifford Jones, describes the very serious problem of liability issues and the untold amount of time, money and grief that are expended even when the defendant was blameless. The other two, one from Chuck Stone and the other from Scripps Howard News, lament the high cost of medical care in this country. To quote Mr. Stone, "That's why so many Americans die needlessly. They cannot afford minimum health care. No estimates are available on the thousands of Americans who die each year because they cannot afford health care or it is not available to them." His premise is that "basic care" which is often "preventive care" should be available to all. These articles on one particular day only serve to underscore the seriousness of the debate now going on in this country. That debate centers on the question, "How can we buy the most health care for our limited dollars?" Infinite demand has reached finite resources.

In addition to the articles mentioned, we have just seen an example of the political process in action in our state. We (MSMA) introduced a bill that to all of us seems to be a basic fairness issue, i.e., the right of the patient to assign the benefits of his health policy to anyone that **he may choose,** not a mandate, but a **choice**. This legistation apparently was perceived as being an attempt to destroy the "Key Physician" network of Blue Cross, and they vigorously opposed the bill. As you are aware, Blue Cross developed a coalition of business, labor, teachers and government and were successful in keeping the bill from a vote in the house and senate.

I write this to make a point. We are in the minority when it comes to **our point of view**. Managed care conjures up nightmares to many of us, but it is the wave of the future in one form or the other. It may take the form of HMO, PPO (Key Physician), or point of contact, but in every case it requires negotiations on the part of the physician. In talking with many of you across the state, you tell me that you are "too busy caring for your patients to get involved in the debate." My question to you is, **"Who is going to negotiate for you?"**

(Continued on page (142)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 4
APRIL 1992

Tribute

It was with great shock and sadness that I received the news that Dr. Carl Evers had been critically injured in a bicycle accident.

Carl is well known to all of us as an outstanding academician, a strong supporter of medicine in general, and an intense and loyal supporter of MSMA.

In his position at the University of Mississippi School of Medicine Carl has been an important liaison between the medical center and the medical community of this state.

I know that all members of this association will join the staff of the *Journal MSMA* in offering prayers for Carl and his family.

Myron W. Lockey, MD
Editor

Comment

The editorials in the March Journal seemed most appropriate to me. the presidents "prescription", stated in his usual able manner, tends to defuse, to some extent, the seething resentment that is building up in the medical community against the federal administration of health care. It also reminds us of our obligation to society.

George Abraham's comments relative to unethical behavior is timely and while the solution is not so simple it helps to be reminded that it exists. Doctors should be obligated to report blatant abuses in their profession and it shouldn't require a bureaucracy to administer some reforms. Abuses or alleged abuses reported to the local medical society and followed by a letter from the ethics committee to the suspected offender might do a great deal to make the guilty pause and consider their actions.

Finally, Joe Johnston's timely comments, relative to the use of expensive drugs, deserves awareness by all the profession. A semi-indigent individual is far better off on HCTZ alone with only partial control of his blood pressure than on more expensive medication that he can't afford and won't buy. It is encouraging that some drug houses recognize this and are offering free certificates to the needy.

It may well "break the bank" if quinolones or their equivalent are prescribed to medicaid recipients when v=cillin or its equivalent would do as well.

W. Moncure Dabney, MD
Editor Emeritus

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Presidents's Page

(Continued from page 140)

The question is rhetorical at this moment, but perhaps not next year, or the next. If we are to survive as a profession, with the ethics that we all espouse, and with the fundamental freedoms that we desire, we must remain strong and committed together in the fight. As was proven in the state battle over the right of assignment, we are few, and those who oppose us are many. When you transpose this to the national scene it becomes an even more staggering figure. Our only hope is to have a strong federation of states with a singleness of voice, **the AMA**, representing all of us. I recognize that many of you will immediately say that your specialty society will represent you, and I agree that they will represent your specialty, but will they represent me? When we have multiple specialty societies attempting to represent multiple groups, then we have war and divisiveness and we are conquered.

We must be "at the table." We are not looking for a handout, but we are in the best position to help make and direct decisions on the future of health care in this country.

What is it to be, managed care, gatekeeper, or some other yet unannounced acronym? There will be something. If we continue to "manage not to care," then perhaps we deserve what we get. ❑



OUR AMA IN ACTION

Physicians dedicated to the health of America

The mission of the American Medical Association is to promote the science and art of medicine and the betterment of the public health. We believe it is important for all physicians to be aware of what the AMA has accomplished recently to further this mission on behalf of our profession and the public we serve. Here are just a few of the many issues the AMA is addressing at this time, based on policies of its House of Delegates which is composed of physicians elected by state medical associations and specialty societies throughout the country:

Cost, Quality and Access to Health Care - The AMA has developed and is recommending a national policy on this issue titled "Health Access America." This AMA policy statement addresses coverage for the medically uninsured, health care cost containment and tort reform. "Health Access America" builds on the strengths of our present health care system and provides our profession a seat at the table where national health care reform will take place.

Medicare Reform and a Resource Based Relative Value Schedule. - The AMA has recently stated that much work remains to reach an equitable reform of the Medicare program. Efforts are continuing for this purpose. Thus far, the AMA's initiatives for Medicare reform and a Resource Based Relative Value Schedule have stopped enactment of medicare "Expenditure Targets" and preserved fee for service medicine in lieu of capitated or DRG payments for physicians' services.

AIDS - The AMA has been in the forefront of efforts to address the AIDS issue on behalf of the public and our profession. Among its many activities, the AMA has organized an AIDS education program for the public that resulted in 38,000 community presentations and has represented health care concerns about AIDS before the Supreme Court. The AMA has particularly been involved in resolving the many complex issues surrounding the testing of physicians and other health workers for AIDS. As recently as last year, the AMA led efforts that blocked unwise efforts by Congress to require mandatory testing of all practicing physicians for AIDS.

Medical Education - Starting with its support of "The Flexner Report" in 1910 and continuing today, the AMA has led efforts to develop a system of medical education in this country that is recognized as the best in the world. These efforts include support of adequate funding for medical education, research and student loans. The American Medical Association Education and Research Foundation (AMA-ERF) annually solicits and contributes millions of dollars to medical schools throughout the country. Last year AMA-ERF contributed $36 million to the University of Mississippi School of Medicine.

Ethics - The AMA's "Principles of Medical Ethics" and "Current Opinions and Reports of the AMA Council on Ethical and Judicial Affairs" are the foundation on which our profession is built. Recent ethical guidelines have dealt with current medical issues such as physician ownership of medical facilities and sponsorship of continuing medical education activities.

The AMA is the voice of physicians. It's the one body in medicine today that represents the collective interest and opinions of physicians in this country. This is a time when we need a unifying force in the medical profession. **The AMA is that unifying force.**

This message is brought to you by your Mississippi State Medical Association Board of Trustees and Officers.


WE'RE ALWAYS ON CALL.
1-800-352-2226
Call the travel specialists toll-free!
When you come down with the urge or necessity to travel, call Avanti for expert service. Everything we do for you is free of charge, even the phone call.
Our travel specialists will take care of all your plans, plane reservations, car rental, hotel accommodations and much more. We're here to help you with charters, tours, cruises, personal vacations, business meetings and conventions.
The next time you make travel arrangements, remember Avanti is always on call, toll-free.
AVANTI
TRAVEL, INC.
Three Lakeland Circle • Jackson, Mississippi 39216 • 981-9111
Call Toll-Free Nationwide 1-800-327-4236

IT TOOK YOU MANY YEARS TO BECOME A PHYSICIAN...

MPIC
Mississippi State Medical Association Sponsored Insurance Plans

Why spend one more minute looking for LIFE INSURANCE?

The Mississippi State Medical Association, Manhattan National Life, and BellMED Insurance Resource Center Inc., have joined together to offer MSMA endorsed SIMPLIFIED ISSUE Term Life plans. Our current SUPERSAVER XV long term, low cost plan offers MSMA members, their staff and spouses these benefits...

★ **GUARANTEES**

— In these days of economic and financial uncertainty, we are pleased to offer you a 15 YEAR RATE GUARANTEE

— Your premium stays level and cannot be increased for the next 15 years...and that's guaranteed

— The coverage is guaranteed renewable to age 95

★ **SIMPLIFIED ISSUE**

— NO EXAM or BLOODWORK*

— NO SALESPERSON VISIT

— ONE PAGE APPLICATION

★ **VERY LOW RATES**

— example: $200,000 preferred non-smoker — annual rate guaranteed for 15 years

Age 40	=	**$400**
Age 45	=	**$554**
Age 50	=	**$800**

IF YOU HAVE ALREADY TAKEN ADVANTAGE OF THE PROGRAM...*THANK YOU!*

BELLMED

If you have not, we think SIMPLIFIED ISSUE SuperSaver XV makes sense. For rates and information, call BellMED at

1-800-456-8042

Manhattan National Life

*Manhattan National Life does reserve the right to request additional information.

What employers — like doctors — are asking Employer Plus.

Q. ***Should an employer provide benefits for employees, or just give them a raise in pay and let them fend for themselves?***

A. *If a pay raise is given, it will cost you as the employer additional dollars by increasing the employer matching social security taxes and increasing worker's compensation premiums. However, if you provide them with employer paid benefits, you will not incur these additional costs.*

Q. ***Will my employees settle for benefits rather than pay increases?***

A. *A study done by the Harvard Business School during the late 80's found that employees rated increased benefits as the next best thing to a raise in pay.*

How Employer Plus can help!

Good benefits help to retain good employees. And, if you split the cost of the benefits with the employees, both of you will come out ahead.

Here's why.

Employer Plus offer our clients an IRS Qualified "Section 125 Cafeteria Plan" for their employees' benefits plan. This plan allows each employer to withhold a portion of its employees' salary to be used to pay for insurance premiums, medical expenses, dependent care, and savings for retirement. The amount that each employee sets aside from their salary to pay for these benefits is tax exempt from FICA Withholdings, Federal Income Tax Withholdings and State Income Tax Withholdings.

In doing this, a bigger take-home amount is produced for your employees, even though you the employer have not actually given them a raise. The increase simply comes from the amount that employees' were paying the government in tax dollars.

Here is just a sample of the benefits that Employer Plus offers our clients in our Cafeteria Plan. All of these benefits are with top-of-the-line, national companies:

- **Health Insurance**
- **Dental Insurance**
- **Vision Insurance**
- **Disability Income Insurance**
- **Life Insurance**
- **Dependent Care**
- **Medical Reimbursement**
- **Retirement Plans**
- ***... and more***

Employer Plus has saved the best part for last...

Our Cafeteria plan will lower your labor cost. For every dollar that your employees run through the Cafeteria Plan — you the employer — will save 7.65%, because you will not have to pay the employer matching share of social security tax. Also, worker's compensation premiums are not calculated on benefit bonuses.

If you are interested in giving more to your employees — and taking home more money from your practice — give us a call.

We have many ways we can save you money!

Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.

In association with Bryan Tours, INC.

ASTA American Society of Travel Agents

Call of the Wild

INTERNATIONAL OUTDOOR TRAVEL, INC.

"For The Wilderness Adventure of a Lifetime"

1929 Dunbarton Dr. - Jackson, MS 39216-5074
P.O. Box 5506 - Brandon, MS 39042

MARK H. GALLAGHER, Owner/Agent
J. VINCENT PHILLIPS, Owner/Agent

The variety of game and activities offered by **CALL OF THE WILD** are as follows:

Freshwater Fishing:

* Smallmouth Bass
* Largemouth Bass
* Striped Bass
* Peacock Bass
* Payara
* Crappie
* Brown Trout
* Rainbow Trout
* Cutthroat Trout
* Brook Trout
* Lake Trout
* Salmon
* Pike
* Walleye

Saltwater Fishing:

* Blue Marlin
* Striped Marlin
* White Marlin
* Black Marlin
* Sailfish
* Swordfish
* Dolphin
* Permit
* Cobia
* Redfish
* Bonefish
* Speckled Trout
* Tarpon
* Wahoo
* Tuna
* And many other species

Hunting:

* White-Tailed Deer
* Mule Deer
* Elk
* Moose
* Antelope
* Bighorn Sheep
* Bear
* Mountain Lion
* Exotics
* Duck
* Goose
* White-Wing Dove
* Quail
* Turkey

Outdoor Activities:

* White Water Rafting
* Scuba Diving
* Cattle Drives
* Photographic Safaris
* And other outdoor activities



We believe your CALL OF THE WILD outdoor experience should be more than just hunting and fishing. It will include lodging, friendly and attentive service, fine food, breathtaking views and much, much more. We stake our reputations on it. We appreciate the opportunity to serve you.

Sincerely, Mark H. Gallagher
Mark H. Gallagher

Sincerely, J. Vincent Phillips
J. Vincent Phillips

CALL OF THE WILD 1992 Spring/Summer Scheduled Tours

May 15-24, 1992
Fish Costa Rica

at the famous Parismina Tarpon Rancho for *Rainbow Bass, Tarpon and Snook.* See for yourself the magnificent Rainforest! Personally Escorted by Mark Gallagher, host of Hawgs 'n Horns TV show. Limited to 15 spaces.

June 6-13, 1992
Fish Venezuela

for *Peacock Bass* at Guri Lodge and see what everyone is talking about! Personally escorted to Venezuela by Vince Phillips, producer of Hawgs 'n Horns TV show. Limited to 15 spaces – enroll early!

Marlin Fishing

Fish one of the most famous Marlin fishing grounds in the world. The North Drop off shore of St. Thomas, US Virgin Islands. 4, 5 and 7 day packages are available. Book now for Summer 1992 accommodations at the Sapphire Beach Resort and Marina.

Elk and Mule Deer Hunting

on a private 16,000 acre ranch. Now is the time to book your Big Game Hunts to Colorado, Flat Tops area, South of Mecker - part of the migration route of the largest Elk heard in Colorado. Guided by the best Big Games Outfitters in the West. **1992 Season** *1st* Oct 10th-14th, --- *2nd* Oct 17th-28th, --- *3rd* Oct 31st-Nov 8th.

Call for details: 601-981-1345 800-872-8522(MS) 800-647-5296(USA) Fax: 601-981-9335

Mississippi State Medical Association

OFFICIAL CALL

To: All Members of the Mississippi State Medical Association

The 124th Annual Session of the Mississippi State Medical Association is called to meet in Jackson, Mississippi on Wednesday, April 29, 1992, pursuant to Article V of the Constitution. The House of Delegates will be convened at the Ramada Renaissance Hotel at 9:00 a.m. on April 30.

The Scientific Assembly will meet May 1 and May 2.

No member or guest will be permitted to participate in any aspect of the Annual Session until regularly registered.

James C. Waites, MD
President
Don Q. Mitchell, MD
Secretary-Treasurer

124th Annual Session
Ramada Renaissance Hotel, Jackson

MSMA's 124th Annual Session will be held at the Ramada Renaissance Hotel in Jackson, Mississippi, Wednesday, April 29, - Sunday, May 3, 1992. Individual room reservations should be made directly with the Ramada Renaissance, 1-800-227-5489. A room registration form was enclosed in the March *MSMA Report.*

The annual President's Reception will be held, Thursday, April 30, at 6:00 p.m. at the Jackson Zoological Park. The MSMA/MSMA Auxiliary Membership Party will be held, Saturday, May 2, at 6:30 p.m. in the Grand Ballroom of the Ramada Renaissance and will feature outstanding entertainment. The MSMA Auxiliary will once again hold a silent auction with the proceeds benefiting AMA-ERF.

House of Delegates

The opening session of the House of Delegates will convene on Thursday, April 30, at 9:00 a.m. Speaker of the House Dr. Vann Craig of Natchez requests that all delegates be certified and in place at 9:00 a.m.

Special guest speaker will be Dr. John J. Ring, president of the American Medical Association. Delegates will also hear an address by Dr. James C. Waites, MSMA president.

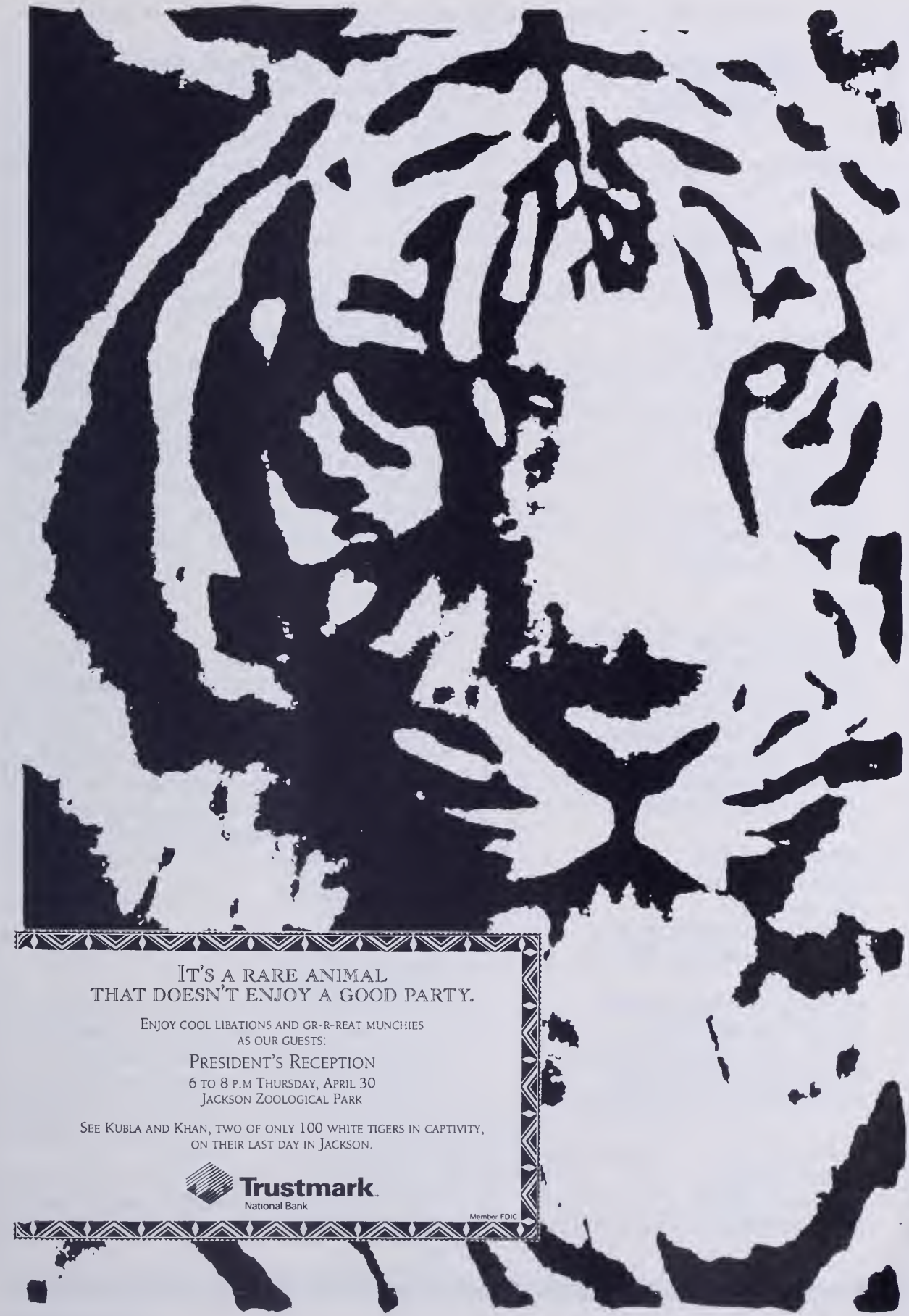
Reports and resolutions will be introduced at the initial meeting of the House for consideration by Reference Committees which are set to meet on Thursday and Friday afternoons. The MSMA 1992 Community Service and other awards will be presented during the opening session.

Delegates will reconvene on Sunday morning, May 3, to take action on policy recommendations and to elect MSMA officers for 1992-93. The installation of Dr. William C. Gates, of Columbus as MSMA president for 1992-93 will mark the official conclusion of the 124th Annual Session.

Parameters of Care
Their Future for Medicine

MSMA's Hospital Medical Staff Section (HMSS) and Young Physician Section (YPS) will host a session on Practice Parameters which is **open to all annual session participants.** This session will take place on Thursday, April 30, at 2:00 p.m. Speakers include: J. Jarret Clinton, MD, Administrator, Agency for Health Care Policy and Research, Department of Health & Human Services; John T. Kelly, MD, PhD, Director, Office of Quality Assurance and Assessment, American Medical Association and Robert H. Sebring, PhD, Director, Division of Care, American Academy of Pediatrics.

The HMSS and YPS will meet separately for their individual business sessions at 3:30 pm.


IT'S A RARE ANIMAL
THAT DOESN'T ENJOY A GOOD PARTY.
ENJOY COOL LIBATIONS AND GR-R-REAT MUNCHIES
AS OUR GUESTS:
PRESIDENT'S RECEPTION
6 TO 8 P.M THURSDAY, APRIL 30
JACKSON ZOOLOGICAL PARK
SEE KUBLA AND KHAN, TWO OF ONLY 100 WHITE TIGERS IN CAPTIVITY,
ON THEIR LAST DAY IN JACKSON.
Trustmark.
National Bank
Member FDIC

124th Annual Session

Summary of Daily Events

WEDNESDAY, APRIL 29
- Golf Tournament
- Tennis Tournament

THURSDAY, APRIL 30
- Continental Breakfast - Exhibit Area
- House of Delegates
- MS Foundation for Medical Care Annual Meeting
- Parameters of Care - Their Future for Medicine
- HMSS/YPS Section Meetings
- Reference Committee
- President's Reception

FRIDAY, MAY 1
- Continental Breakfast - Exhibit Hall
- Medicine Plenary Session
- MSMA Auxiliary House of Delegates
- MS Academy of Family Physicians
- MS Society of Internal Medicine
- MS Psychiatric Association
- Reference Committee Meetings
- Medical Alumni Functions

SATURDAY, MAY 2
- Surgery Plenary Session
- Fifty-Year Club
- MSMA Auxiliary Home Tour
- MS Chapter, American College of Surgeons
- MS Society of Anesthesiologists
- MS Dermatological Society
- MS Chapter, Emergency Physicians
- MS Association of Pathologists
- MSMA/MSMAA Membership Party

SUNDAY, MAY 3
- Catholic Services
- Protestant Services
- House of Delegates

Scientific Programs

The Medicine and Surgery Plenary Sessions are Scheduled for Friday, May 1 and Saturday, May 2. Program information is outlined on page 151 of this issue of *Journal MSMA*. CME accreditation for the plenary sessions has been applied for and will be published in the official program.

Residents and Medical Students Program

UMC residents and medical students will meet for a special program on how the federation of medicine (AMA, state association and county societies) work to represent the medical profession and address public health issues. This program will be held Thursday, April 30 at 4:00 pm in Ballroom B.

Speakers for the program will include officers and Council members of the AMA and MSMA.

Technical Exhibits

This year's Technical Exhibit features 48 displays of the latest in resources for physicians. The program includes two contiental breakfasts and one luncheon in the exhibit area. This was planned to provide MSMA members with additional opportunities to view the exhibits and talk with the professional representatives who will be available to provide information. Members are eligible for numerous exhibit registration awards.

MSMA Auxiliary

The MSMA Auxiliary will be conducting their 69th Annual Session during the week. Complete program information is on page 153 of this issue.

MSMA and MSMA Auxiliary members will again have the opportunity to enjoy coffee, soft drinks, and homemade refreshments in the Auxiliary's Hospitality Center.

The MSMA Auxiliary will hold a silent auction prior to the Membership Party on Saturday, May 2. The proceeds from this auction will benefit the AMA ERF.

SCIENTIFIC PROGRAMS

Friday, May 1, 1992
Medicine Plenary Session

Challenges in Geriatrics: Aiming For Our 80's

8:00 am	Opening Remarks Dr. Dave Duddleston, Chairman Plenary Session
8:15 am	Interest in Geriatrics as a specialty Dr. Mac Addison, Jackson
8:30 am	Treatment of Hypertension in the Elderly - emphasis on end organ damage Dr. Hector Ventura, New Orleans
9:30 am	Gut Erosions and NSAID Gastropathy Dr. Michael Levinson, Memphis
10:15 am	Break
10:45 am	Panic Disorder Dr. Michael Wise, New Orleans
11:30 am	Benzodiazepine Abuse in the Elderly Dr. Brent Meador, Jackson
11:45 am	Closing Remarks Dr. Dave Duddleston

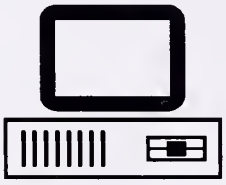
Saturday, May 2, 1992
Surgery Plenary Session

New Technology: Triumph or Trivial Pursuit

8:00 am	Technology Assessment: An Overview Dr. Robert S. Rhodes, Chairman Plenary Session, Jackson
8:40 am	Ethical Issues Dr. Ruth Black, Jackson
	Specialty Perspectives:
9:00 am	Urology Dr. Ronald Krueger, Jackson
9:15 am	Ob-Gyn Dr. G. Rodney Meeks, Jackson
9:30 am	Neurosurgery Dr. Lon F. Alexander, Jackson
9:45 am	Break
10:00 am	Emergency Medicine Dr. E. Jackson Allison, Jr.
10:30 am	Otolaryngology Dr. C. Ron Cannon, Jackson
10:45 am	Techonolgy Assessment: Government Perspectives Dr. David S. Mulder, Montreal
11:30 am	Panel Discussion Drs. Alexander, Allison, Black, Cannon, Krueger, Meeks, and Mulder

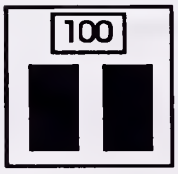
TECHNICAL EXHIBIT

MSMA
124th Annual Session
Ramada Renaissance Hotel
Jackson, MS
April 29 - MAY 3, 1992









EXHIBITOR	BOOTH
Ayerst	36
Bedsole Medical Companies, Inc.	1 & 2
BFI Medical Waste System	10
Charter Hospital of Jackson	35
CIBA-Geigy Corporation	26
CIBA Pharmaceutical	4
DP Associates, Inc.	12
The Doctor's Company	28
Encyclopaedia Britannica North America	18
Glaxo, Inc.	25
Gulf South Lithotripsy	13
Healthcare Suppliers, Inc.	39
I.C. Systems, Inc.	6
Independent Computer Service, Inc.	37
Jackson Recovery Center	38
Key Pharmaceuticals	32
Medical Assurance Company of MS	47
Medical Pathology Laboratory, LTD	11
Merck, Sharp & Dohme	14
Miles, Inc.	29
MS Baptist Chemical Dependency Center	30
MS Foundation for Medical Care	15
MS Methodist Rehabilitation Center	3
MS Physicians Insurance Company	21
MS State Department of Health	16
MSMA Benefit Plan & Trust	19
OSHA Information	48
Parke-Davis	41
Pfizer Labs	34
Professional Disability Associates	20
Puckett Laboratory	23
River Bay Corporation	40
Salcris Systems	24
Sandoz Pharmaceuticals	7
Shearson Lehman Brothers	46
Sims Prosthetics	5
SmithKline Beecham Pharmaceuticals	8
Sta-Home Health Agency, Inc.	33
Summit Pharmaceuticals	45
Sunflower Three	42
Travelers Medicare	17
The Trusty Company, Inc	22
U.S. Air Force	43
U.S. Army Medical Department	27
University Medical Center, Biochemical Genetics Lab	31
Weight Watchers	9
Wyeth-Ayerst Pediatric/Female Health Care	44

Mississippi State Medical Association Auxiliary

Schedule at a Glance

WEDNESDAY, APRIL 29

3:00 p.m. - 5:00 p.m.	**Registration** Main Corridor **Hospitality Center** Cabana

THURSDAY, APRIL 30

8:00 a.m. - 4:00 p.m.	**Registration**
9:00 a.m. - 4:00 p.m.	**Hospitality Center**
11:00 a.m.	**Pre-Convention Board Meeting/Luncheon** Magnolia I
6:00 p.m. - 8:00 p.m.	**MSMA President's Reception** Jackson Zoo

FRIDAY, MAY 1

9:00 a.m. - 12:00 noon	**Hospitality Center** Cabana (Ramada Renaissance)

JACKSON COUNTRY CLUB

8:45 a.m. - 9:00 a.m.	**Continental Breakfast**
9:00 a.m. - 12:00 noon	**House of Delegates**
12:00 noon	**Luncheon**
2:30 p.m.	**Post-Convention Board Meeting**

SATURDAY, MAY 2

8:00 a.m.		**Past-President's Breakfast** Magnolia I
10:30 a.m.		***"Brushstrokes & Brunch"***
6:30 p.m.	Cocktails	**MSMA-MSMA Auxiliary Membership Party**
7:00 p.m.	Dinner	Grand Ballroom



ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

AXID®
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

1. Data on file, Lilly Research Laboratories.

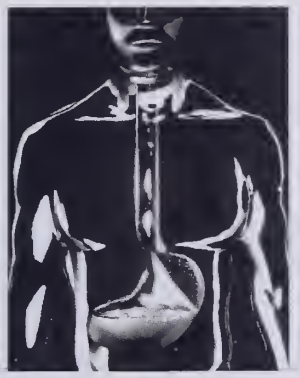
See accompanying page for prescribing information.

© 1991, ELI LILLY AND COMPANY

NZ-2947-B-249304

AXID®

nizatidine capsules



Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2 receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

We earn
your trust every day.℠

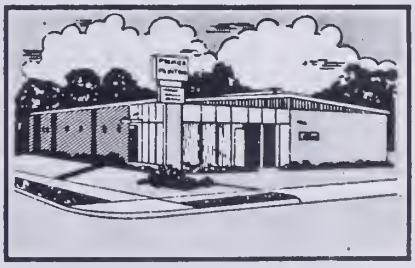
Trustmark℠
National Bank

Jackson/Bogue Chitto/Brandon/Brookhaven/Canton/Clinton/Columbia
Florence/Flowood/Georgetown/Gloster/Greenville/Greenwood/Hattiesburg
Hazlehurst/Hernando/Horn Lake/Leland/Liberty/Madison/Magee/McComb
Olive Branch/Pearl/Pelahatchie/Petal/Richland/Ridgeland/Southaven
Tylertown/Wesson

Member FDIC

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Personals

Gene Barrett of Jackson recently presented a study on anterior cruciate ligament reconstruction at the Anterior Cruciate Ligament Study Group in Vail, CO. He also presented a study on posterior cruciate ligament reconstruction at the American Academy of Orthopaedic Surgeons in Washington, DC. He will also present two papers on anterior cruciate and posterior cruciate reconstruction in Orlando at the Mid American Orthopaedic Association.

William M. Barr of Clarksdale was inducted as a fellow of the American Academy of Orthopaedic Surgeons during ceremonies at the Academy's 59th annual meeting in Washington, DC.

Sandra F. Burford a Vicksburg family physician, has been invited to speak at the State Special Education Conference and Institute. Dr. Burford will address the medical aspects of Attention Deficit Disorder; diagnosis and treatment.

Harry L. Butler a hematologist and oncologist practicing in Hattiesburg, recently achieved certification as a Diplomat in the sub-specialty of Medical Oncology.

R. J. Field, Jr. of the Field Clinic and Field Hospital, Centreville, Mississippi spoke at the University of South Alabama School of Medicine's surgical faculty in January. His presentation was entitled *A Proposed Program for Rural Surgery Training.*

Brooks Griffin of Jackson announces the relocation of his office to 1045-B North Flowood Drive, Jackson.

Bill Maddox and Wesley Marner have announced their association in the Maddox Marner Clinic. They begin seeing patients on February 17 in the Washington County Health Clinic building on Lake Street in Glen Allan, MS.

William S. Mayo of Oxford served as a volunteer in the AOA Care-A-Van in Southaven, MS as a part of the osteopathic medical profession's centennial celebration --*Osteopathic Medi-*

Physicians' Recognition Award

Seven MSMA members were named recipients of the AMA Physicians' Recognition Award in February 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These seven individuals are presented below by medical society.

CENTRAL

William Fredrick Krooss, MD
James S. McIlwain, MD
Robert Smith, MD
Catherine H. Stroud, MD
Charles Hartwell Williams, MD

NORTHEAST

Samual J. Creekmore, Jr., MD
Shelby C. Reid, MD

cine: A Century of Making a Difference. The American Osteopathic Association (AOA) is providing free health care screening to the medically underserved as the Care-A-Van travels throughout the 48 contiguous states.

William S. Renaudin has associated with the Woman's Clinic PA, Obstetrics-Gynecology, 1967 Hospital Drive - 1621 N. State Street, Jackson.

Rudolph S. Runnels, of Magee has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

David L. Spencer has recently successfully completed his recertification examinations giving by the American Board of Surgery.

John J. White of Jackson recently presented a slide lecture to The Flying Physician's Association at Amelia Island, Fla., on *Handling The IRS Tax Audit.* ❑

For Comments or Queries

The Editors of *Journal MSMA* invite you to comment on any material that appears in or is absent from the publication. If you have a query or comment, please sent it to: The Editor, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

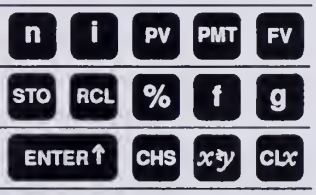
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- No-Load Mutual Funds/Other Securities
- 23 Years Experience
- Tested Asset Allocation Model
- Fee-Only Advisor

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720



"When I realized my chances of becoming disabled by age 65 were *three times greater* than the chances of death . . .

I compared disability insurance plans. And I decided that my MSMA-endorsed disability insurance plan

SERVES ME BEST!

It's not group insurance, but an individually-owned policy which is *non-cancellable* and *guaranteed renewable.*"

If you're a member of the Mississippi State Medical Association you may be eligible for this outstanding professional disability plan at *discounted premiums*.

- Non-cancellable, guaranteed renewable
- Medical specialty protection
- Presumptive loss provision
- Indexing of prior earnings
- Waiver of premium
- Cost of living rider
- Future disability insurance option
- Lifetime accident and sickness rider
- Total and residual disability protection

Offered by Paul Revere Insurance Company to MSMA members through its exclusive representatives, Professional Disability Specialists.

Jon B. Wimbish, Disability Specialist

1501 Lakeland Drive, Suite 200 Jackson, MS 39216 Telephone 362-9800

MSMA-SPONSORED
Standard Insurance Claims Forms
HCFA 1500

☐ • **Old two-part snap-out, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part snap-out, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$37.25 Plus State Sales Tax**	**$45.00 Plus State Sales Tax**

☐ • **Old two-part continuous, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part continuous, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$39.00 Plus State Sales Tax**	**$47.00 Plus State Sales Tax**

- **All orders plus 6% Mississippi Sales Tax unless your organization is tax exempt**
- **Price includes all delivery and handling costs**
- **Rapid Shipment via UPS**

ORDER INFORMATION

RETURN ORDER BLANK TO:

Order Department - Insurance Forms
Mississippi State Medical Association
PO Box 5229
Jackson, MS 39296-5229

Call in orders:

(Toll Free In-State Wats)	1-800-898-0251
Jackson and surrounding area	354-5433
MSMA Fax Number	352-4834

SHIP ORDER TO:

_____
_____
_____
_____
(Please indicate street address and zip code)

_____
(name of individual placing order)

_____
(purchase order #)

_____
(phone #)

Placement Service
Physicians Wanted

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Emergency Medicine Opportunities -- Spectrum Emergency Care, the nation's largest provider of emergency department staffing and management services, currently has full and part-time staff physician opportunities at select client hospitals in Mississippi. As an independent contract physician, you will enjoy a variety of geographical locations in both large and small hospitals. Spectrum also offers participation in an occurrence-based malpractice insurance program, flexible scheduling, administrative support, and the opportunity for advancement. To learn more about the exciting opportunities currently available, **call Dan Fuller at 800/325-3982, ext. 7809.** Spectrum Emergency Care, 999 Executive Parkway, St. Louis, MO 63141.



Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

LIBRARY
JUN 08 1992
N.Y. Academy of Medicine

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

ORTHOPEDIC SURGERY - Louisiana - to be affiliated with highly regarded, well-established orthopedic surgeon. Supported by 212 - bed medical center providing a first year net guarantee between $200-250K based on experience. Additionally, office rent, business systems augmentation, a nurse, and on-line computer system will be provided at no cost to the first year physician. Finally, practice quality medicine and control your destiny from the inception. Excellent outdoor recreational opportunities. Contact Jim Wiederhold, Lowderman & Haney, Inc., 3939 Roswell Rd., NE, Suite 100, Marietta, GA 30062, (800) 486-3020 or use our fax (404) 977-6549.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

Community Health Center located in East Central Mississippi is seeking a **Family or Internal Medicine Physician** to practice in a rural health area. Urban or rural life styles are possible. Competitive salary, malpractice, incentives and attractive benefits are provided. Send Curriculum Vitae to Mr. Wilbert L. Jones, Greater meridian Health Clinic, 2700 6th Street, Meridian, MS 39301 Equal Employer Opportunity.

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119



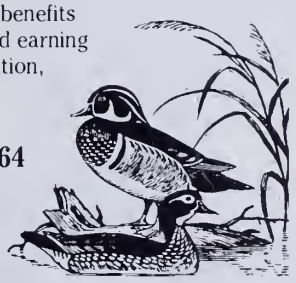
Orthopaedics

Outstanding opportunity for an Orthopaedic Surgeon to join a thriving practice in a community of 68,000 near Little Rock. Very busy orthopaedist affiliated with a large, state-of-the-art facility seeks an associate for his practice. Opportunity to practice general orthopaedics and develop subspecialty interests.

New orthopaedic offices, with over 3,300 square feet are located in the new medical tower adjoining the medical center and are equipped with the latest technology.

Good call coverage from other orthopaedists, as well as a good base of physicians for back-up and referrals.

Generous compensation and benefits package. Excellent growth and earning potential. For further information, contact:



Greg Foster
1 (800) 626-1857, ext. 264
Suite 250, Browenton Place
2000 Warrington Way
Louisville, KY 40222

SOUTHERN INDEPENDENCE

Large practice, small town. Established Family Medicine group in pre-revolutionary Pee Dee area community seeking physicians for a life-time commitment. New building, equipment, facilities, unequaled elsewhere. A truly special career opportunity in Family Medicine for a special physician. It don't get no better - friendly town with excellent quality of life. BC/BE only, please. $100,000+. Want more info? Contact:

Cheraw Family Medicine
Attention: C. Radkin
PO Box 867
Cheraw, South Carolina 29520
(803) 537-2171. Call collect.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

Family Practice/ ER Physician needed on a regular weekday basis (15 to 20 hours a week) and to work alternate Saturday's. North East Jackson. Call 957-2273.

CHANDELEUR ISLAND FISHING

OMECO III

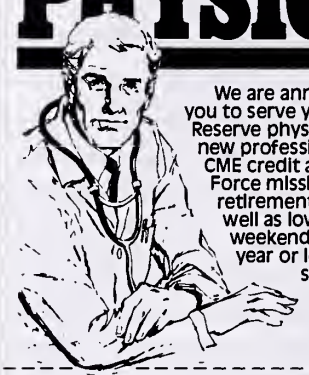
60' Twin Diesel
Air Conditioned
14' Fiberglass Skiffs
Outboard Motors
Oversized Bunks
All Meals Provided



Specializing in Trout and Redfish
601-432-2054 Biloxi, MS

Items for the Placement Service should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (404)421-4892

Or Fill Out Coupon and Mail Today!
To: SMSGT Hartung
14 AF/RSH
Dobbins AFB, GA 30069

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE

A GREAT WAY TO SERVE

Classified

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

FOR SALE: Tingle TXR 9 Radiographic unit. General practice with Flat Bucky table. Less than 2 years old. For more information call (601) 762-3664.

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captian Mike McRaney, (601) 875-946, PO Box 999, Biloxi, MS.**

Index to Advertisers

Avanti 144

Call of the Wild Adventure Travel 147
CancerPay Plus **8**

Deposit Guaranty Investments 130
Disability Determination 162
Doctors Insurance Reciprocal **6**

Eli Lilly & Co. ..... 154 & 155
Employer Plus, Inc. **146**

Harreld Chevrolet-Oldsmobile 142

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 157
MS Emergency Association 161
MS Methodist Rehabilitation Center.. **second cover**
MS Physicians Insurance Company **4**
MS State Department of Health 137
MSMA Benefit Plan & Trust 136
MSMA Sponsored Insurance Plan 145

Palisades Pharmaceuticals 135
Parke Davis ..... 160A & 160B
Physician Services of America 163
Post Graduate Medicine 128
Premier Printing 155

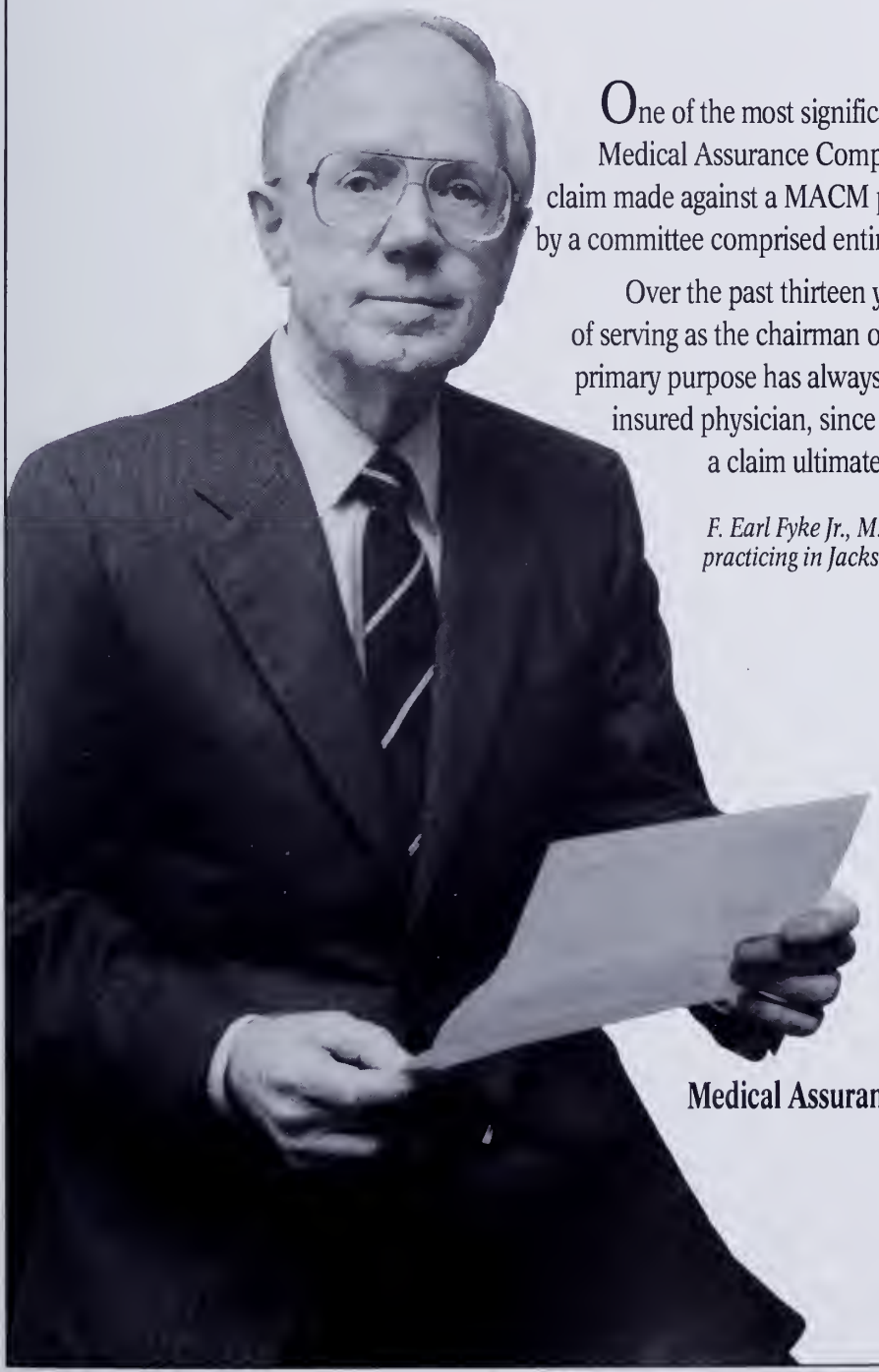
Searle ..... **fourth cover**
St. Stanislaus 129

The Doctors' Company 158
Trustmark 155

US Air Force 139
US Air Force Reserve 164
US Army Reserve **7**

Jon Wimbish 159

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

For the many faces of mild hypertension



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION[1]*

- Effective 24-hour control[2]
- Single-agent efficacy
- Well tolerated†
- No adverse effects on total cholesterol, plasma glucose levels, renal function,‡ or serum electrolytes[3-6]

ONCE-DAILY
Calan® SR
verapamil HCl 180 mg
SUSTAINED-RELEASE CAPLETS 240 mg

For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitently with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the petient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia end rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

© 1992 Searle

A92CA6506T

SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MAY 1992



William C. Gates, M.D. — 1992-1993 MSMA President



They took little sticks and touched me. It felt like a dream.



"A dream" is how Sandi Fornea described the nightmare she thought she'd never wake up from. A cheerleader and campus beauty who seemed to be living a charmed life, she felt her body gradually go numb from a rare virus. The way Sandi saw it, her paralysis had changed her whole life for the worse. And that's when the staff at MMRC set out to change her mind.

"They respected me," said Sandi. "They didn't patronize me or treat me like a child. They taught me that if you believe in yourself, you're okay."

Sandi's illness opened her eyes to the fact that there are thousands of people like her, and made her want to do for others what the staff at MMRC had done for her.

Teaching others to believe in themselves is what rehabilitation is all about. It's what makes MMRC the South's leading rehabilitation center.

Just ask Sandi. Today she's fully recovered, and studying to be a physical therapist.

And she'll probably tell you it feels like a dream.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MAY 1992 VOLUME XXXIII NUMBER 5

SCIENTIFIC ARTICLES

Primary Care Physicians in Mississippi: Implications for Rural Health Care 165
Ronnie Boyd, MURP and Michael H. Bross, MD

Graduate Follow-up in the University of Mississippi Family Practice Residency Program 171
Robert C. Forbes, MD and Elizabeth Walley, MSEd

SPECIAL ARTICLE

Report of the AMA Council on Ethical and Judicial Affairs: Reporting Impaired, Incompetent, or Unethical Colleagues 176

EDITORIALS

The Inauguration - And Thoughts It Provoked 178
William C. Gates, MD

"Doctor, I've Read ....." 179
Joseph E. Johnston, MD

DEPARTMENTS

Letters 182
Medical Organization 186
From the University of Mississippi Medical Center 192
Personals 196
Placement Service 200

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
William C. Gates, MD
President
Don Q. Mitchell, MD
President-Elect
D. Stanley Hartness, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 5

Wastewater Managment Law

Jackson, MS - Dirty toilet tissue and raw sewage running in open ditches could become commonplace throughout Mississippi if the Legislature fails to pass an adequate wastewater management law. "We need a strong wastewater management program," affirmed State Health Officer Dr. Alton B. Cobb. "To allow surface discharge of human wastes is an invitation to disease and epidemics as well as creation of an environmental blight on our state."

Public health officials fear a resurgence of such dread diseases as cholera and typhoid fever. Health officials last spring confirmed *Vibrio cholerae,* the organism that causes cholera, in oysters and other selfish from Mobile Bay, and other nearby states routinely report sporadic cases of cholera. "Finding cholera organisms underlines the importance not only of not eating raw seafood but also underscores our need for strong wastewater management laws," Dr. Cobb said. "Conditions along our southern borders foreshadow the potential for a cholera epidemic here."

In January 1992, Mississippi State Department of Health epidemiologists confirmed that a 14-month-old girl from rural Mississippi had typhoid fever. Typhoid infection occurs with ingestion of the organism *Salmonella typhi,* usually through fecal contamination of food or water. In 1191, the nation reported 456 cases of typhoid; by comparison, in the 1920's an average of 2,000 cases per year occurred in Mississippi alone. "Through the development of protected water supplies, improved sewage systems, and the pasteurization of milk," Dr. Cobb traced, "we steadily decreased the incidence of typhoid fever, cholera, and other such diseases in the United States and Western Europe. We cannot allow Mississippi to regress to such a deplorable, filthy, and dangerous state."

During the 1992 session, Legislators did introduce wastewater management proposals in both the House and the Senate. But the joint chamber's Environmental Protection Council bills died. Senate Bill 2562 -- dramatically different from the EPC bill -- has passed its original chamber and awaits House action; public health officials say the bill fails to provide adequate wastewater management but can be used as a vehicle to get a good law.

"The bill needs some major modifications, including EPC recommendations, to provide the public health protection that Mississippians deserve and the state must have to ensure orderly growth and environmental quality," said Lydia Strayer, MSDH sanitation director. Ideally, the individual onsite wastewater management law should require approval of all sewage disposal systems before building begins, Strayer said.

She said the SB 2562 does not require pre-approval but does stipulate that the system should be "environmentally sound and...designed, constructed, installed, operated and maintained in such a manner to prevent wastes from leaving the property of the generator." Additionally, both the current law and SB 2562 require a licensed, certified installer.

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

The ACCUPRIL Single-Agent Commitment™

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.*†



New!

ONCE-A-DAY‡

ACCUPRIL®™

quinapril HCl tablets 10, 20, 40 mg

* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

© 1991 Warner-Lambert Company

PARKE-DAVIS

Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (l%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro chromosome* aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuance)	Placebo (N = 579) Incidence (Discontinuance)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) ot the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, *heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances*

Gastrointestinal: dry mouth or throat, constipation, *gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests*

Nervous/Psychiatric: somnolence, vertigo, syncope, *nervousness, depression*

Integumentary: increased sweating, pruritus, *exfoliative dermatitis, photosensitivity reaction*

Urogenital: *acute renal failure*

Other: amblyopia, pharyngitis, sinusitis, bronchitis, *agranulocytosis, thrombocytopenia*

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0. 1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit ot normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, ot patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

New!
ONCE-A-DAY*
ACCUPRIL®
quinapril HCl tablets

* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

PD-103-JA-7164-A2(022)

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings Up To 15 %
✔ 2. Established by Your Association	
✔ 3. Savings over what you currently are paying	
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association



Mac Hadden graduated from St. Stanislaus in 1973, valedictorian of his class. He went on to be valedictorian at Tulane University where he earned a bachelor's degree in engineering and an MBA. Today, he is president of Standard Supply and Hardware Company in New Orleans.

"St. Stanislaus provided a stable environment in which I could recognize and develop my own personal abilities."

To the Brothers of the Sacred Heart, every student is a potential leader. And giving him the proper example — spiritual, intellectual and moral — is our mission at St. Stanislaus.

SAINT STANISLAUS
BOARDING SCHOOL GRADES 6-12 SUMMER CAMP AGES 9-14
OPENINGS FOR DAY STUDENTS GRADES 7-12
304 South Beach Blvd. Bay St. Louis, MS 39520

FOR A FREE BROCHURE CALL THE DIRECTOR OF ADMISSIONS — (601) 467-9057

St. Stanislaus helps build leaders.

Primary Care Physicians in Mississippi: Implications for Rural Health Care

RONNIE BOYD, MURP
MICHAEL H. BROSS, MD

Despite a 24% increase in Mississippi primary care physicians during the 1980s, rural areas of the state continue to be underserved with 39 of 82 counties classified as health manpower shortage areas for primary medical care. Utilizing 1980 and 1990 census data and reports from the Mississippi State Department of Health, primary care physician manpower was analyzed to determine where growth and trends occurred. Most of the primary care physician growth occurred in ten populous counties, with family physicians and general practitioners continuing to provide most of the care in the lesser populated counties. Public and private entities are exploring new and innovative methods of delivering health care to rural areas which recognize the changing professional and lifestyle expectations of today's physicians. Multispecialty primary care group practices need to be promoted and innovative financial arrangements provided. Educational systems need to recruit students from rural areas and provide more training experiences in rural areas.

The year 1990, the target year for the predicted physician surplus, has passed. In 1979, the Graduate Medical Education National Advisory Committee predicted a surplus of 70,000 physicians by 1990 and a surplus of 150,000 physicians by the year 2000.[1] This physician surplus, along with free market forces, was predicted to resolve physician shortage and maldistribution problems. While the total number of physicians has increased markedly, many areas of the country remain underserved by primary care physicians.

Mississippi followed this national trend. While the state's population grew only 2.1% from 1980 to 1990, there was a 30.2% increase in active physicians and a 24.3% increase in primary care physicians.[2,3] This overall increase in primary care physicians reduced the population to primary care physician ratio during the 1980's from 2,236.6 to 1,842.0. Despite this physician growth, Mississippi still has 39 of 82 counties classified as health manpower shortage areas for primary medical care (Division of Planning, Mississippi State Department of Health, October 1991).

This article examines the supply and distribution or primary care physicians in Mississippi from 1979 through 1990. The purpose is to understand primary care trends and prepare for the future.

METHODS

Primary care physicians are defined as family physicians, general practitioners, general internists, and pediatricians. Using the 1979 and 1990 editions of Physicians in Mississippi,[2,3] changes in active primary care physicians were tabulated. Primary care physicians changes by county were recorded for the period to ascertain which counties had the largest numerical increases.

Using 1990 census data, counties were grouped by size. Primary care physician ratios were determined for each county population grouping. Primary care physicians specialties were then correlated with county populations. To anticipate primary care physician needs, the number of physicians over age 60 were calculated by specialty.

RESULTS

Although total primary care physicians increased by 272 from 1979 to 1990, they decreased from 43.3% to 33.3% as a percent of all active physicians. Among primary care physicians, family practice had the largest increase of 199, followed by internal medicine with 178 and pediatrics with 61. These increases were offset by a decrease in general practitioners of 166 (see Table 1). There was a net increase of nearly 25 primary care physicians per year. Almost two-thirds of the primary care physician growth occurred in ten counties, with the largest increase in Hinds County (see Table 2).

In 1990, primary care physician density was directly related to county population (see Table 3). The three most populous counties (Hinds, Harrison, and Jackson) averaged 1,105 people per primary care physician. The 26 counties with less than 15,000 population averaged 3,016 people per primary care physician. By specialty, less populous counties were served largely by family and general practitioners (see Figure 1). In the 50 counties with less than 25,000 population, family and general practitioners comprised 85.9 percent of the primary care physicians. In the 12 counties with populations in excess of 50,000 general internists and pediatricians comprised 64.9 percent of the primary care physicians.

Twenty-one percent of all primary care physicians (total 292) were over age 60 in 1990. General practitioners had the largest percent over age 60 (47%), followed by family physicians (23%), pediatricians

TABLE 1. Active Primary Care Physician in Mississippi 1979 and 1990

Specialty	1979	1990	Increase (Decrease)	% Increase (Decrease)
Fam. Practice	306	505	199	65.0
Gen. Practice	375	209	(166)	(44.3)
Int. Medicine	276	454	178	64.5
Pediatrics	167	228	61	35.5
	1,124	1,396	272	24.2

TABLE 2 Counties With Largest Numerical Increase in Primary Care Active Physicians

County	7/1/79 P.C.Physicians	7/1/90 P.C. Physicians	Increase
Hinds	282	350	68
Desoto	6	37	31
Rankin	18	38	20
Harrison	78	91	13
Forrest	32	43	11
Lee	36	48	12
Lowndes	20	33	13
Lamar	4	17	13
Madison	13	23	10
Lauderdale	51	61	10
	540	708	168

Table 3. Population Per Primary Care Physician By County Size - 1990

County Population	Number of Counties	Total Population	Primary Care Physicians	Pop. Per Physician
100,000+	3	535,049	484	1,105.5
50,000 - 99,999	9	607,589	341	1,781.8
25,000 - 49,999	20	672,546	309	2,176.5
15,000 - 24,999	24	480,504	171	2,810.0
Less than 15,000	26	277,528	92	3,016.6
Total	82	2,573,216	1,397	1,842.0

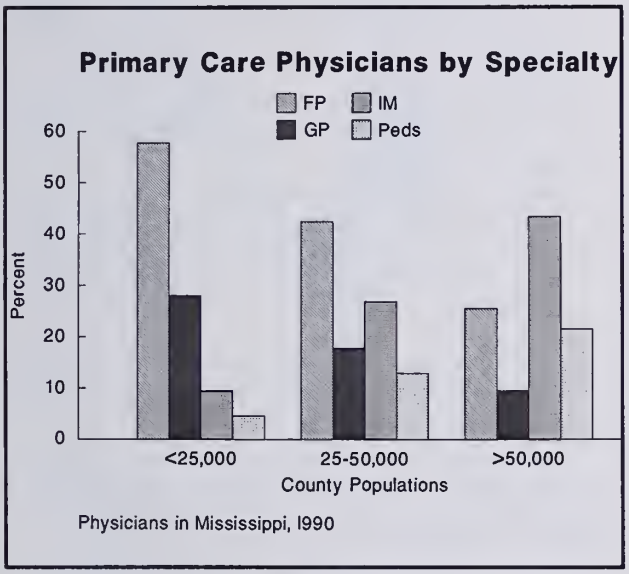


Figure I

(11.4%), and internists (11.2%).

DISCUSSION

During the 1980s, Mississippi's low population growth contributed to a reduction in the population to primary care physician ratio. Despite this trend, there still is a maldistribution of primary care physicians. Primary care physician growth is largely occurring in the more populous counties. Assuming that a minimum population to primary care physician ratio of 2000/1 is appropriate, the 50 counties with populations <25,000 need 160 more primary care physicians.

Our data consistent with national findings, indicates that general and family practice physicians are providing most of the care in rural areas.[4] Family medicine training is largely ambulatory in nature and includes all ages, allowing for greater physician "comfort" in the absence of other specialists. Internists and pediatricians require a larger population base for successful practices. With limited internists and pediatricians in rural areas, cross coverage within the specialty is difficult.

Mississippi has taken several steps to help alleviate the maldistribution problem. Mississippi passed House Bill 1020 in April, 1991, consolidating health related student loan programs and providing more flexibility to providers choosing to locate in underserved areas. The Mississippi State Health Department has recently initiated an office of rural health. The Mississippi Primary Health Care Association, comprised of over 20 community health centers, supports and aids in the recruitment of primary care physicians to underserved areas. The University of Mississippi School of Medicine requires that each third year medical student complete a family medicine preceptorship, predominately located in rural areas. This emphasis has contributed to the University of Mississippi ranking fifth, of the 126 public and private medical schools, in the percentage of graduates entering family medicine in the 1980s.[5] The Department of Family Medicine has also developed a Physician Placement Service which assists communities that are seeking family physicians. This service has over 60 communities on file, representing a need of approximately 90 family physicians. Family medicine residents are required to take a rural medicine month, choosing from 35 available sites. The Department of Pediatrics offers a rural elective month for second and third year residents.

Several larger hospitals and clinics in the state are establishing networks and linkages to rural physicians and small community hospitals. Such arrangements provide needed capital and manpower, strengthening the delivery of health care to the local communities.

Communities need to be educated on how to recruit and retain today's graduating physicians. Today's physicians have specific concerns regarding financial incentives and lifestyle issues. Nationally, family medicine residency graduates owed a median of over $52,000 in 1989, up from $28,000 in 1984.[6] Loan repayment, guaranteed salary, and start up assistance are attractive benefits. Rural family physicians work longer hours and see more patients than urban family physicians.[6] New physicians, increasingly concerned with lifestyle issues, desire time for family and recreation. With more and more women becoming physicians, communities need to be even more sensitive to lifestyle issues. Small communities should consider developing regional health care systems. Instead of each small community seeking its own physicians, communities would join in their recruiting efforts. This larger population base could better support a primary care physician group. Group practices, comprised of the primary care specialties, would facilitate cross coverage for pediatricians, internists, and family physicians. Primary care colleagues would ease professional isolation. The American Academy of Family Practice's Compass program has found that the vast majority of new family physicians prefer group practice.

Educationally, more emphasis needs to be placed on rural primary care. More consideration should be given to medical school applicants who are from smaller communities. Such students are more likely to select family medicine and return to rural areas.[7-9] Primary care residencies should provide more rural training opportunities. Resident practice experience in rural areas, with limited access to consultants and the latest technology, will improve self-confidence, thus facilitating a return to rural areas.[10] Residency training should provide the knowledge and procedural skills necessary for rural physicians to reach their career and income goals.

While recognizing that other factors, such as lower Medicare reimbursement, contribute to primary care physician maldistribution, this article has concentrated on suggestions that can be implemented by local communities and the physician education system. By positively influencing a physician's professional and lifestyle opportunities through innovative and new practice arrangements, rural areas can greatly enhance their abilities to attract and retain primary care physicians. By placing emphasis on rural training experiences, residency programs can prepare physicians for the uniqueness of rural practice. ❑

2500 North State Street
Jackson, MS 39216-4505

ACKNOWLEDGEMENTS

We wish to thank D. Melessa Phillips, MD and Diane K. Beebe, MD, for their critical reviews of the manuscript; and Bonnie J. Toop for assistance with manuscript preparation.

REFERENCES

1. Report of the Graduate Medical Education National Advisory Committee to the Secretary. Washington, DC: US Dept of Health and Human Services; 1981. Publication GPO 0-721-728.
2. Office of Public Health Statistics. *Physicians in Mississippi.* Jackson, Mississippi: Mississippi State Board of Health, 1980.
3. Board of Medical Licensure. *Physicians in Mississippi.* Jackson, Mississippi: Mississippi State Board of Health, 1990.
4. Barnett PG, Midtling JE. Public policy and the supply of primary care physicians. *JAMA* 1898;262(20):2864-2868.
5. Schmittling G, Graham R, Tsou C. Entry of US medical school graduates into family practice residencies:1989-1990 and nine-year summary. *Fam Med* 1990;22(2):130-136.
6. American Academy of Family Physicians. *Facts About: Family Practice.* Kansas City: American Academy of Family Physicians, 1990:20-21,97.
7. Brazeau NK, Potts MJ, Hickner JM. The upper peninsula program: a successful model for increasing primary care physicians in rural areas. *Fam Med* 1990;22(5):350-355.
8. Ernst RL, Yett DE. Physicians background characteristics and their career choices: a review of the literature. *Med Car Rev* 1984;41:1-36.
9. Rabinowitz HK. Evaluation of a selective medical school admissions policy to increase the number of family physicians in rural and underserved areas. *N Engl J Med* 1988;319:480-486.
10. Politzer RM, Harris DL, Gaston MH, Mullan F. Primary care physician supply and the medically underserved: a status report and recommendations. *JAMA* 1991;266(1):104-109.

Mr. Boyd is the director of Primary Care Outreach, Department of Family Medicine, and **Dr. Bross** is an assistant professor in the Department of Family Medicine, University of Mississippi Medical Center.



"When I realized my chances of becoming disabled by age 65 were *three times greater* than the chances of death . . .

I compared disability insurance plans. And I decided that my MSMA-endorsed disability insurance plan

SERVES ME BEST!

It's not group insurance, but an individually-owned policy which is *non-cancellable* and *guaranteed renewable.*"

If you're a member of the Mississippi State Medical Association you may be eligible for this outstanding professional disability plan at *discounted premiums*.

- Non-cancellable, guaranteed renewable
- Medical specialty protection
- Presumptive loss provision
- Indexing of prior earnings
- Waiver of premium
- Cost of living rider
- Future disability insurance option
- Lifetime accident and sickness rider
- Total and residual disability protection

Offered by Paul Revere Insurance Company to MSMA members through its exclusive representatives, Professional Disability Specialists.

Jon B. Wimbish, Disability Specialist

1501 Lakeland Drive, Suite 200 Jackson, MS 39216 Telephone 362-9800

THE UNITED STATES ARMY RESERVE
HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM
$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

Graduate Follow-Up in the University of Mississippi Family Practice Residency Program

ROBERT C. FORBES, MD
ELIZABETH WALLEY, MSEd

The University of Mississippi established a university-based, community-affiliated family practice residency training program in 1973 to counteract the problem of a dwindling number of primary care providers to a rural state. The primary goal of the program has been to increase the supply of competent family physicians to the state of Mississippi, and was recently expanded by faculty consensus to include improving the health care of the people of Mississippi.

From the first class of four who completed the three-year residency in 1976, the program has grown to accommodate 14 residents per post-graduate year (see Table 1). The program is state funded and has been augmented over the years by various grants. The first year is university based at the University of Mississippi Medical center in Jackson. The second and third years are community based, with residents seeing patients at one of two off-campus Family Practice Centers and admitting their patients to one or more of three Jackson community hospitals. Through 1989, a total of 126 residents had graduated from the residency. This study was initiated to determine the practice locations and practice profiles of these graduates, with implications for assessing the accomplishment of the department goal.

Table 1. University of Mississippi Department of Family Medicine Residency Program 1973-1989

Year	Graduates	Year	Graduates
1976	4	1983	8
1977	5	1984	13
1978	9	1985	9
1979	11	1986	9
1980	7	1987	9
1981	10	1988	7
1982	12	1989	13
		Total	**126**

METHODS

A questionnaire, Table 2, was sent to all University of Mississippi Medical Center Family Medicine Residency graduates from 1976 through 1989. The questionnaire included 24 items which could be answered by single-word or multiple-choice response and elicited information regarding physician credentials, practice size, location, and description. Level of satisfaction with career choice and residency training were both assessed. Demographics included the graduates' age, race, and gender. The name of the respondent was not indicated on the survey form. After an initial mail-out, telephone contacts brought the total number of respondents to 120 out of 126. (One graduate of 1981 died several months after completing his residency, five graduates did not respond and could not be reached by telephone).

RESULTS

Tables 3 and 4 summarize some of the data collected. Eighty percent of the 120 graduates surveyed have remained in the state and 95 percent are board-certified. Twenty-seven percent (32) are in solo practice, 38 percent (46) are in a partnership or group and another 10 percent (12) are in a multi-specialty group. Ten percent (12) are practicing emergency medicine, two percent (2) are in public health and nine percent

Table 2. University of Mississippi Medical Center Department of Family Medicine Residency Survey

1. Male ____Female ____
2. Black ____White ____ Other ____
3. Age ____
4. Are you ABFP Certified? Yes ____ No ____
5. In what type of practice do you currently work?
   __ a. solo
   __ b. partnership
   __ c. group (family med)
   __ d. multi-specialty group
   __ e. HMO
   __ f. ER
   __ g. public health
   __ h. academic medicine
   __ i. other _____
6. Are you practicing family medicine? yes ___ no____
7. If group or partnership, how many are in your group (including yourself)? _____
8. Approximately how many hours per week do you work?
   __ a. 40 or less
   __ b. 41-50 hours
   __ c. 51-60 hours
   __ d. 61 or more
9. On the average, how many patients do you see in your office each day? ____
10. On the average, how many hospital patients do you have each day? ____
11. Do you perform deliveries? Yes ____ No ____
12. Do you accept Medicaid? Yes ____ No ____
13. Do you participate in Medicare? Yes ____ No ____
14. Do you provide x-ray services in your office? Yes ____ No ___
15. Do you provide lab services in your office? Yes ____ No ____
16. Do you think there are too many family physicians in your service area? Yes____ No ____
17. Are you as busy in your practice as you want to be? Yes ____ No ____
18. What year did you begin practice? _____
19. How many times have you changed practice communities? _____
20. What is the population of your community ?
   __ a. less than 2,000
   __ b. 2,000-5,000
   __ c. 5,001-10,000
   __ d. 10,001-15,000
   __ e. 15,001-25,000
   __ f. 25,001-50,000
   __ g. greater than 50,000
22. How many years have you practiced in your community? _____
23. How satisfied are you with your career choice?
   __ very satisfied
   __ somewhat satisfied
   __ neutral
   __ somewhat dissatisfied
   __ very dissatisfied
24. Do you feel that your residency prepared you for practice? Yes ____ No ____
25. If no, comments? _____
   _____
   _____

Table 3. Responses to Questionnaire N=120

Gender		
male	95	(79%)
female	25	(21%)
Race		
white	102	(85%)
black	12	(10%)
other	6	(5%)
Practice		
in-state	96	(80%)
out-of-state	24	(20%)
Board Certified		
yes	114	(95%)
no	6	(5%)
Practice Type		
solo	32	(27%)
partnership	22	(18%)
group	24	(20%)
multi-specialty	12	(10%)
ER	12	(10%)
public health	2	(2%)
faculty	9	(7%)
HMO	1	(1%)
other*	6	(5%)

(9) are family medicine faculty (seven at UMC). Six graduates who listed practice type as "other" include physicians practicing in ophthalmology, dermatology, missionary medicine, military medicine, fellowship training, state hospital service (2) and one who is not in practice.

Fifty-seven percent practice in a community of less than 25,000. Fourteen percent are practicing obstetrics. Seventy-two percent and 63 percent accept Medicaid and Medicare respectively. Ninety-three percent have an office lab while only 77 percent have in-office X-ray.

The median age of graduates at the time of the survey was 36. Of those in a partnership or group, 85 percent were in a group of less than four. Seventy percent worked over 50 hours per week. Median values for office visits and hospital patients per day were 28 and 4 respectively. Seventy-five percent of graduates are still practicing in the community in which they established their practice immediately following their residency training. Eighty-nine percent were sat-

Table 4. Responses To Questionnaire (Excluding Faculty, ER and other)		
*** Doing Obstetrics?**		
yes	12	(13%)
no	79	(87%)
*** Accept Medicaid?**		
yes	62	(68%)
no	29	(32%)
***Accept Medicare?**		
yes	53	(58%)
no	38	(42%)
***Office Lab?**		
yes	71	(78%)
no	20	(22%)
***Office X-ray?**		
yes	85	(93%)
no	6	(7%)
Community size		
< 2,000	4	(4%)
2,001 - 5,000	9	(10%)
5,001 - 10,000	11	(12%)
10,001 - 15,000	16	(17%)
15,001 - 25,000	13	(14%)
25,001 - 50,000	15	(16%)
> 50,000	25	(27%)
*** does not include 2 "non responses"**		

isfied with their career choice and 95 percent felt that the residency prepared them for practice.

DISCUSSION

Results of this study indicated progress toward the goals of the Department of Family Medicine, ie., to provide competent family physicians for and improve the health care of the people of Mississippi. One limitation of the study is the lack of in-depth questioning of the study design, which may lead to oversimplification of the interpretation of the physicians' responses. A second limitation is the inability of the study to assess adequately the department's success toward the recently amended goal statement of the department.

Findings of this survey appear to correlate well to findings of prior research on graduate practice profiles. With findings similar to ours, earlier studies indicate a preference of residency graduates for solo or group practice types,[1] a high degree of practice activity satisfaction,[2] and the tendency to stay in the initial practice site.[1,3-5] Our study also indicates a much lower percentage of graduates doing obstetrics than reported by other programs and surveys.[1,2] This finding probably reflects recent medico-legal changes in our health care system that make obstetrics less attractive for inclusion in practice. Satisfaction with the level of training in the residency and preparation for the "real world" seems to be higher among our graduates than reported in prior research. However, there is wide variation in perceived training strengths and weaknesses in these earlier studies.[2-4]

In conclusion, the study results indicate progress toward the departmental goals. Longitudinal tracking studies of practice patterns and career satisfaction should be implemented to identify new trends among residency graduates. While most graduates are happy with their career choice and believe that the residency prepared them adequately for practice, continued assessment will assist the department in evaluating the residency training program.

SUMMARY

Practice profiles in 120 University Medical Center Department of Family Medicine residency graduates were assessed by questionnaire and follow-up telephone calls. Physician credentials, career satisfaction, and evaluation of residency training were also addressed. Findings include some preferences for partnership or group practice settings and practices in communities of less than 25,000. Eighty percent of graduates remain in Mississippi, and most are satisfied with their careers and the residency training they received. Changing patterns in areas such as obstetrical care provided and Medicare/Medicaid acceptance suggest new surveys may be needed to provide the department with information that will assist in meeting its goals.□

2500 North State Street
Jackson, MS 39216-4505

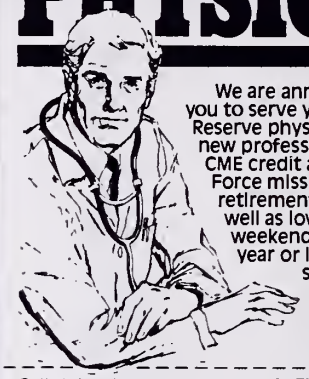
REFERENCES

1. Black II RR, Schmittling G, Stern TL. Characteristics and Practice Patterns of Family Practice Residency Graduates in the United States. *Jnl Fam Pract* 1980;11(5):776-778.
2. Price JG, Liese BS. Graduate Follow-Up of UKSM-KC Family Practice Residency Training. *Kansas Medicine* 1987;88(5):155-158.
3. Mayo F, Wood M, Marsland D, Jacoby KE, White SB. Graduate Follow-up in the Medical College of Virginia/

Virginia Commonwealth University Family Practice Residency System. *Jnl Fam Pract* 1980;11(5):731-742.
4. Hecht RC, Farrell JF. Graduate Follow-Up in the University of Wisconsin Family Practice Residency Programs. *Jnl Fam Pract* 1982;14(3):549-555.
5. Brazeau NK, Potts Michael J, Hickner, JM. The Upper Peninsula Program: A Successful Model for Increasing Primary Care Physicians in Rural Areas. *Family Medicine* 1990;22(5):351-354.

Dr. Forbes is assistant professor of Family Medicine and **Ms. Walley** is an instructor in Family Medicine, both from the Department of Family Medicine, University of Mississippi School of Medicine.

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (404)421-4892

Or Fill Out Coupon and Mail Today!
To: SMSGT Hartung
14 AF/RSH
Dobbins AFB, GA 30069

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE

A GREAT WAY TO SERVE

COME SEE THE BEAUTIFUL NEW MODELS NOW!

HARRELD CANTON

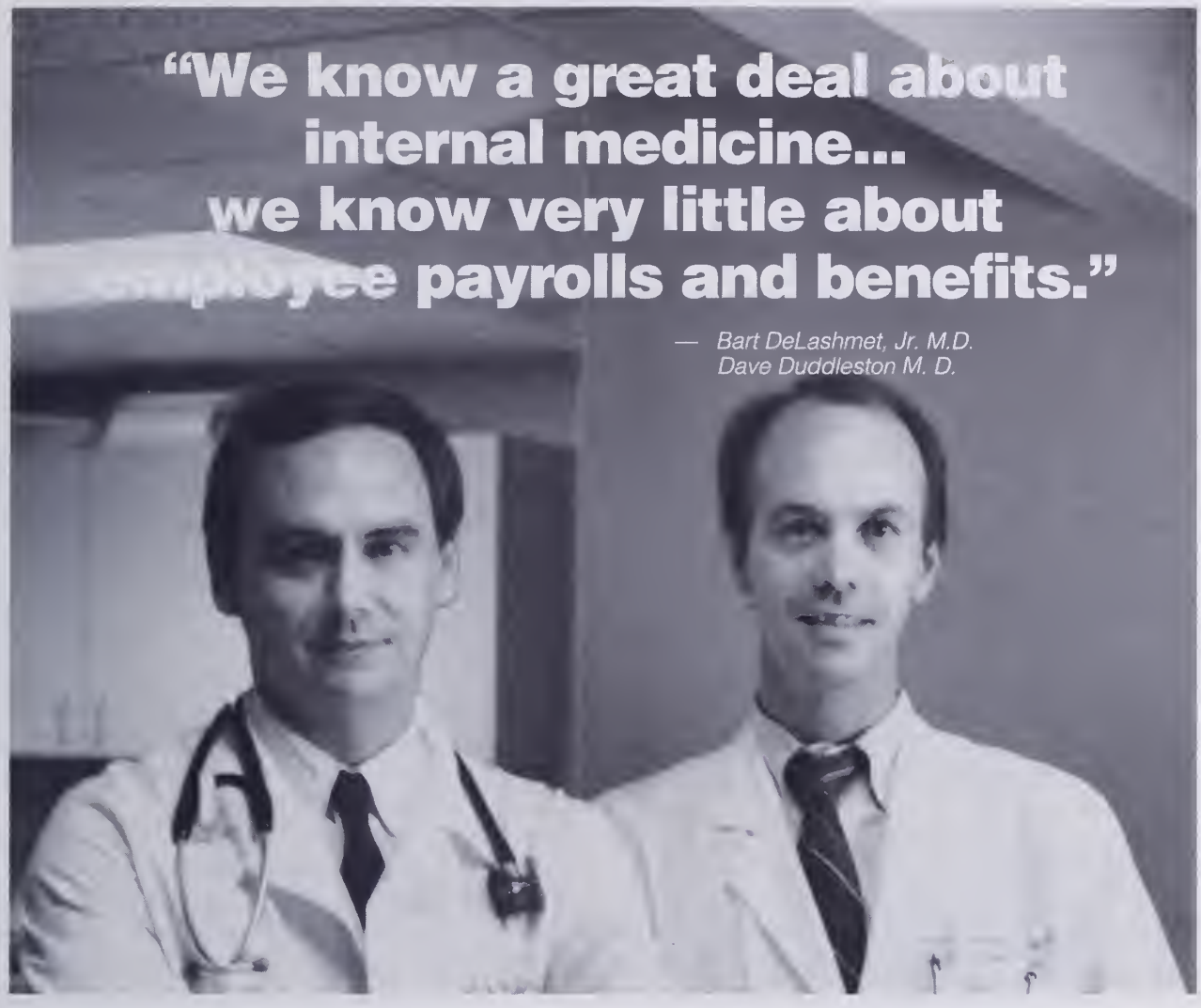
Member of CENTRAL MISSISSIPPI Dealer

CALL US 1-800-451-3908 TOLL FREE!

MISSISSIPPI'S FAVORITE COMBINATION CHEVY-OLDS-GEO DEALER

HARRELD CHEVY-OLDS-GEO

Canton 859-1611 Highway 51 South - Canton, MS Jackson 354-2233



Specialization.

In today's professional environment, it pays to concentrate one's energies in the areas of one's expertise.

So, when Dr. Bart DeLashmet, Jr. and Dr. Dave Duddleston, *specialist* in internal medicine and partners in the Central Medical Clinic, made the decision to contract with Employer Plus, they showed an appreciation of someone else's area of *specialization.*

They recognized what more and more small business executives and professional acknowledge: in hiring Employer Plus, a firm that *specializes* in employee payroll and benefits management and other employee administrative matters, they could save time, money and aggravation. Also, they could offer their employees a more complete package of benefits, including a cafeteria plan. And, satisfied employees make longer lasting employees.

Just as the doctors, nurses and staff of the Central Medical Clinic focus their attention on the practice of internal medicine, Employer Plus concentrates its efforts on employee management.

If you have a sick feeling that you are spending too much time on non-productive administrative task and not enough time on your practice, call Employer Plus, today.

We've got the right prescription.

In fact, we're just what the *doctors* ordered!

Employer Plus, Inc.

4537 Office Park Drive • P.O. Box16283
Jackson, MS 39236-6283 • (601) 366-7293 • 1-800-844-0093

No one administers payroll and employee benefits, better!℠

©1991 Employer Plus, Inc All rights reserved.

Special Article

Report of the AMA Council on Ethical and Judicial Affairs: Reporting Impaired, Incompetent, or Unethical Colleagues

The medical profession has a long tradition of self-regulation. This tradition is based, at least in part, on the unique qualifications physicians possess, by virtue of their specialized knowledge and skills, to evaluate the clinical performance of their colleagues.

The Council on Ethical and Judicial Affairs has developed a series of guidelines to assist physicians in fulfilling their ethical obligation to report the potentially injurious conduct of colleagues.

Physicians should be familiar with the reporting requirements of their own state and comply accordingly.

1. IMPAIRMENT
   a. Impairment should be reported to the hospital's in-house impairment program, if available. If no in-house program is available, or if the type of impairment is not normally addressed by an impairment program, e.g., extreme fatigue and emotional distress, then the chief of an appropriate clinical service, the chief of staff of the hospital or other appropriate supervisor (e.g., the chief resident) should be alerted.
   b. If a report cannot be made through the usual hospital channels, then a report should be made to an external impaired physician program. Such programs typically would be operated by the local medical societies or state licensing boards.
   c. Physicians in office-based practices who do not have clinical privileges at an area hospital should be reported directly to an impaired physician program.
   d. If reporting to an individual or program which would facilitate the entrance of the impaired physician into an impaired physician program cannot be accomplished, then the impaired physician should be reported directly to the state licensing board.
2. INCOMPETENCE
   a. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action, e.g., the chief resident, the chief of an appropriate clinical service, the chief of the hospital staff, or the medical director of a group medical practice.
   b. The individual who receives a report of incompetence should, in turn, notify the hospital peer review body where appropriate. Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the state licensing board.
   c. Instances of incompetence by physicians who have no hospital affiliation should be reported to the local or state medical society.
   d. Continued behavior that is potentially injurious to patients must further be reported to the state licensing board.
   e. If the incompetence is of a sufficiently serious nature as to pose an immediate threat to the health of the physician's patients, then it should be reported directly to the state licensing board.
3. UNETHICAL CONDUCT.

Unethical behavior (which does not fit into the category of either incompetence or impairment) should be reported in accordance with these guidelines:

   a. Unethical conduct which threatens patient care

or welfare should be reported to the appropriate authority for a particular clinical service, i.e., the chief resident, the chief of an appropriate clinical service, or the chief of the hospital staff.

b. Unethical behavior which violates the provisions of the state licensing board should be reported to the state licensing board.

c. Unethical conduct which violates criminal statutes should be reported to the appropriate law enforcement authorities.

d. Examples of unethical conduct which do not fall into the above three categories, or unethical conduct which has not been addressed through other channels should be reported to the local or state medical society.

4. Where the impairment, incompetence or unethical behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. In order to aid physicians who report inappropriate behavior of colleagues in carrying out this obligation, the person or body receiving the initial report should notify the reporting physician when appropriate action has been taken.
5. Physicians should work to assure that state laws provide immunity to those who report impaired, incompetent or unethical colleagues.
6. In certain circumstances, an anonymous report may be the only practical method of alerting an authoritative body to a colleague's misconduct. Anonymous reports of misconduct should receive appropriate review and confidential investigation by authorities.
7. Principles of due process must be observed in the conduct of all disciplinary matters involving physician participants at all levels. However, the confidentiality of the reporting physician should be maintained to the greatest extent possible within the constraints of due process, in order to minimize potential professional recriminations.
8. The medical profession as a whole must correct misperception that physicians are not adequately protecting the public from incompetent, impaired, or unethical physicians by better communicating its efforts and initiatives at maintaining high ethical standards and quality assurance. ❑

You may obtain a complete copy of this report by contacting the MSMA office.

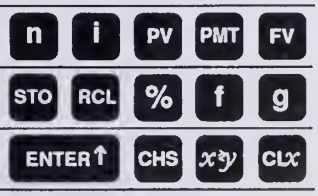
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- **No-Load Mutual Funds/Other Securities**
- **23 Years Experience**
- **Tested Asset Allocation Model**
- **Fee-Only Advisor**

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123



The President's Page

WILLIAM C. GATES, MD

The Inauguration - And Thoughts It Provoked

This article is being penned in anticipation of the April 15 deadline for the May '92 publication of the *Journal MSMA* and, therefore, prior to the annual session and inauguration. The fact that the meeting will have come and gone before you read this in no way serves to diminish my excitement and enthusiasm for the event and its significance to me, even though I am required to write about it *a priori*.

This is, without qualification, the highest honor of my professional life and truly one of the greatest moments of my personal life. The feelings I have are honed and heightened by the level of esteem in which I hold my medical colleagues - simply put, there are no finer people in this world than physicians. I sincerely thank you for the opportunity to serve the House of Delegates, the Board of Trustees and the MSMA membership. I also want to thank my family, friends, component society colleagues and our magnificent MSMA staff for all the help and support over the years and for lighting the path that led to this day. I pledge my best effort and devotion to the duties of this high office. My earnest wish is to be your "personal representative of the medical profession of the State of Mississippi" as stated in *Chapter IX, Section I of the Constitution and By-Laws* of MSMA. I solicit your communication by whatever means possible to inform me of issues you want discussed and problems you would like to see addressed by your association. I cannot promise a satisfactory outcome in every case, but I can promise the expenditure of time and energy and the use of serious consideration in the search for solutions.

I was recently asked what the "theme" for my year as president would be and I have thought about that question a lot. I am not exactly hung-up on or high on the idea of having a "theme" in actuality. If there is any semblance of a theme, it would be "Back to Basics" or "Return to Fundamentals". In my view, the president of the MSMA, to be effective, must be simultaneously a cheerleader, a coach and a player. I think the back to basics concept would serve to emphasize the building blocks of professionalism and the core principles of medicine that make it such a great endeavor. I would also wish to accent those things that we must do in order to preserve the integrity and dignity of the practice of medicine.

Many of our current programs punctuate our concern for the world at large and they need to be carried to completion - for instance: ***Health Access Mississippi*** and the ***Comprehensive Health Education Curriculum*** for Mississippi schools. The Health Fair, jointly sponsored by MSMA and the Auxiliary (we sponsor - they do the work), is very exciting and has enormous

(Continued on page 179)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 5
MAY 1992

" Doctor, I've Read...."

Hardly a day goes by that we don't hear those words. It is not enough to try to keep up with the true scientific literature anymore. You are expected to do that, but also quasi-scientific endeavors as well as the general lay materials on health matters. Now I am asking you, what super-human doctor can keep up with all of this?

Somedays it is almost a game of "one-upmanship" when one patient after another reaches deep inside her purse or he reaches in his front shirt pocket and pulls out this worn scrap of newspaper or a ten page article from a 'wellness' magazine and demands your opinion on some often far-fetched or way-out method of treating this or that.

I usually cringe; take it and read quickly through it; and then wilt in bewilderment. Previously you could always say, "well, it has not been proven yet"; but they have got you now because often times the news media gets the "scoop" before we do. One tack that I find useful in these situations is to tell them that they have indeed found a good idea and that I will take the article so that I can study it more. I promptly file it in their chart and usually never hear about it again.

Truly, I don't know where this journalism is going, but it would seem to me that they will ultimately move from their present "new ground" called "Investigative Reporting" to "Scientific Investigation for Journalistic Potential" as another means by which they can generate news. Then maybe something good might come of all this.

Thank God I am a physician.

Joseph E. Johnston, MD
Associate Editor

Presidents's Page

(Continued from page 178)

potential for good. We need a deeper appreciation for and greater utilization of our wonder women in the Auxiliary. I also want to commend the male spouse members of the Auxiliary - there are not many of them but they do a great job! If there are any finer people in the world than physicians, it would have to be physicians' spouses - the fact that they have **chosen** to devote time and energy to projects like the Health Fair (and many others) automatically elevates them to a higher plane of existence, in my book.

In closing, let me emphasize the fact that now, more than ever before, medicine must present a unified front toward the slings and arrows being fired from the many forces swirling about us at this moment in history. The milieu for organized medicine is now a stormy sea of change - rapid change, as reflected in world events of late. We must be **cohesive, coherent** and **committed** - we must be **involved, inventive and incisive**. The fate and fortune of medicine will literally be decided in the legislative arena and time, money and effort will be needed to influence the rate and nature of the change. Continuing to demonstrate our strong belief in patient advocacy will enhance our credibility in this debate as do programs that enhance the common good.

Please join me and resolve to enlist our colleagues in a renewed, vigorous commitment to our profession and our association.

Thank you, again, for the honor and privilege to serve you as President.

I sincerely hope my musings find you and yours doing well ... best regards.

Bill

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

The American Medical Association, CLIA and You

The federal government has released long-awaited rules to implement the Clinical Laboratory Improvement Act of 1988. The law expands the extent of federal laboratory regulation from the 13,000 labs now regulated to an estimated 200,000.

The bottom line, and the most encouraging news, is that physicians performing in-office tests will be able to continue with current personnel. But, standards will be most stringent for labs doing the most complicated tests.

In response to comments by the AMA and other physician groups, the test categories were changed to more accurately reflect how physicians use tests in caring for patients. Rules governing personnel were modified to allow doctors with one or two years of training or experience to head their own labs. Other personnel rules should be phased in over five years to provide help in rural areas.

The rules were published February 28 in the *Federal Register*. The AMA will work with specialty and state medical societies to modify parts of the rules that still need revision. Early analysis shows that problems remain. For example, it's not clear what kind of experience physicians are required to have to head an office lab. Regulations requiring routine unannounced inspections are apt to disrupt patient care. HCFA's estimate that additional costs will only add 25 cents per test is in question.

Regulations won't be effective until September and then will be phased in over several years to give physicians time to learn and comply. The AMA, working with other medical groups, has already begun to put together educational programs and materials.

Here are the CLIA implementation timetables:

September 1, 1992: Quality standards go into effect. Labs will have to adhere to manufacturers' current instructions, and meet other specific interim quality control requirements. Also, a complete list of lab tests will be published. Enforcement regulations will go into effect.

January 1, 1994: Newly regulated labs, including most physician office labs, must be enrolled in a proficiency testing program.

In most office labs, the physician would serve as the clinical consultant—liaison between the lab and its clients for the purpose of interpreting and reporting test results. Physicians may also serve as technical consultants—the one responsible for technical and scientific oversight of the lab. Between September 1, 1992 and January 1, 1994, test manufacturers should be revising instructions to make them consistent with CLIA requirements and be approved by the FDA.

For now, wait. In the next few months, the government will begin to tell physicians what regulatory category they are going to fall into, how to register and how much to pay.

AMA executive Vice President, James S. Todd, MD said physicians should be "encouraged, but not complacent" about the regulations. "We are cautiously hopeful that these rules can be implemented with the minimal physician impact. But they will clearly have an impact on their offices," Dr Todd said.

OUR AMA IN ACTION

Physicians dedicated to the health of America

The mission of the American Medical Association is to promote the science and art of medicine and the betterment of the public health. We believe it is important for all physicians to be aware of what the AMA has accomplished recently to further this mission on behalf of our profession and the public we serve. Here are just a few of the many issues the AMA is addressing at this time, based on policies of its House of Delegates which is composed of physicians elected by state medical associations and specialty societies throughout the country:

Cost, Quality and Access to Health Care - The AMA has developed and is recommending a national policy on this issue titled "Health Access America." This AMA policy statement addresses coverage for the medically uninsured, health care cost containment and tort reform. "Health Access America" builds on the strengths of our present health care system and provides our profession a seat at the table where national health care reform will take place.

Medicare Reform and a Resource Based Relative Value Schedule. - The AMA has recently stated that much work remains to reach an equitable reform of the Medicare program. Efforts are continuing for this purpose. Thus far, the AMA's initiatives for Medicare reform and a Resource Based Relative Value Schedule have stopped enactment of medicare "Expenditure Targets" and preserved fee for service medicine in lieu of capitated or DRG payments for physicians' services.

AIDS - The AMA has been in the forefront of efforts to address the AIDS issue on behalf of the public and our profession. Among its many activities, the AMA has organized an AIDS education program for the public that resulted in 38,000 community presentations and has represented health care concerns about AIDS before the Supreme Court. The AMA has particularly been involved in resolving the many complex issues surrounding the testing of physicians and other health workers for AIDS. As recently as last year, the AMA led efforts that blocked unwise efforts by Congress to require mandatory testing of all practicing physicians for AIDS.

Medical Education - Starting with its support of "The Flexner Report" in 1910 and continuing today, the AMA has led efforts to develop a system of medical education in this country that is recognized as the best in the world. These efforts include support of adequate funding for medical education, research and student loans. The American Medical Association Education and Research Foundation (AMA-ERF) annually solicits and contributes millions of dollars to medical schools throughout the country. Last year AMA-ERF contributed $36 thousand to the University of Mississippi School of Medicine.

Ethics - The AMA's "Principles of Medical Ethics" and "Current Opinions and Reports of the AMA Council on Ethical and Judicial Affairs" are the foundation on which our profession is built. Recent ethical guidelines have dealt with current medical issues such as physician ownership of medical facilities and sponsorship of continuing medical education activities.

The AMA is the voice of physicians. It's the one body in medicine today that represents the collective interest and opinions of physicians in this country. This is a time when we need a unifying force in the medical profession. **The AMA is that unifying force.**

This message is brought to you by your Mississippi State Medical Association Board of Trustees and Officers.

Letters

To: The Editors of the *Journal MSMA* and the Membership

Feeling Like a 'Real Doctor' Again

Somehow I knew I wouldn't like the RBRVS when I found out that it didn't stand for "Rhythm and Blues Recreational Vehicles". Medical acronyms and initialisms rarely portend anything that's desirable. Whether it's HIV, AIDS, CLIA, DRG's, PPO's, or HCFA, they all spell HTN and PUD to me. Thus far I have managed to look at this latest alphabetical scourge as a complex game that's to be skillfully played, but rarely if ever won. And I'm quite certain that when enough of us LMD's (that's Local Medical Doc's in the University vernacular) master this latest version of the game, "they" will change the rules on us again.

I had never REALLY looked at a CPT-Code book until January of this year when our new one arrived exactly two days before the deadline for submitting the new codes. During this, the absolute busiest time of a physician's year, all I needed was yet another time consuming decision to make on each patient.

Let's see, shall I make Mrs. Snodgrass a 99213 or a 99212? Is a few extra dollars worth the risk of triggering a Medicare audit? I take the gamble. After all, I did have to listen to her litany about having a "chartreuse-colored" nasal discharge. She actually brought in a sample neatly wrapped in tissue for show and tell. I allowed as to how that should easily be worth an extra $2.63. I spent as much time writing up the visit as I did examining the patient. I spent twice as long deciding on a code as I did deciding which antibiotic to use. I feel as if I'm back in the 'House of God', only this time BUFFING and TURFING charts instead of GOMERS.

During the month of February we've had an average of fifty patients a day in the office. On any given day at least half of them are legitimately sick. One day last week in addition to the 25-30 RSP's (Really Sick People) I saw, I had a patient mix that went something like this:

Two guys from a local furniture factory came in to see me because they "had had diarrhea two days ago and just needed a note stating that they had been sick so they could go back to work". This was relatively painless. Three patients came in from various local plants with alleged chronic low back pain who wanted me to help the "get their disability". It just galls me to no end when I see healthy people trying to get on disability. But many of them manage to do it even without my help.

A couple brought in their two-year old for recurrent bronchitis. They chided me because the child was not better after 36 hours on an antibiotic, and also because the cough syrup I had ordered was not covered by her Medicaid card. They didn't buy it. The parents reeked of stale cigarettes, rancid grease and raw onions. Both parents were at least 50 pounds overweight and both had fresh packs of cigarettes in their shirt pockets, but "couldn't afford" to buy their sick child a lousy bottle of cough syrup. As a final note the daddy asked me to write a scrip for him for Tagamet 800 in the toddler's name so that he could "get it on her card". I told him "no" and also that if they would quite smoking he probably wouldn't need the Tagamet and the child might not be sick so much. He got mad at me, but I hope he never comes back.

The same day I had several new Medicaid folks who dropped in for "check-ups" because their regular doctor was unavailable. "But, Doc, you're so busy! If you'll just write me a scrip for my Tylenol 3's and my Xanax I'll get out of you hair."

The when I came back from lunch break a late model Mercedes-Benz with out-of-county VANITY license plates pulled in behind me. I took notice because there are only a couple of Mercedes in Tippah County. When the patient's turn came they were a Medicaid family of five, all with minor colds. They had come to my office because no doctor in their county would honor their "insurance card". So that explains how they could afford the Mercedes. Silly me, I drive a Dodge pick-up.

An hour later I had this other Medicaid patient, a 35 year old woman complaining of nagging neck pain. She was wearing a Benetton blouse, Guess jeans, Reebok pumps, and had four heavy solid gold chains with humongous crosses around her neck. She looked like a blonde Mr. T in drag. She had also apparently bathed in "Beautiful" cologne. At least that's what she said it was. My nurse said it costs about fifty dollars a bottle, but you couldn't prove it by me. Hell, I was wearing a Wal-Mart blouse at the time. After I'd seen her and sent her chart to the front, the office manager came back and told me that he couldn't put her in the computer because he couldn't find a CPT-code for "crucifix-induced cervical spine strain".

Several more 'stinkeroos' passed through our portals that same day. For the life of me I don't see how some people stand themselves. I've

practiced breath-holding techniques for 99211 visits, but for 99214's well-coordinated mouth breathing is required. My nurses are probably single-handedly destroying the ozone-layer with Glade potpourri spray.

Oh, I also saw two drug reps both with the same pharmaceutical company, but detailing different types of drugs. Then I saw another rep from a different drug company who discussed the same drug as the first rep I saw earlier in the day. Confused? Me too.

Mid-afternoon brought what I reckoned would be the last straw for the day. A home health nurse called with the news that one of my long time patients was in his words "just real bad". J.P. Jackson had just been sent home from the hospital by his pulmonologist, after having reached maximum hospital benefit, to spend his final few days in peace at home. But end-stage COPD patients seldom die peacefully. Smothering to death is simply not a favored mode of exit.

The family called to request that I make a house call. They knew he was dying, but wanted me to come and just look at him and tell them if there was anything else they could do to make him a little more comfortable. There had been so much tragedy in this family in recent days. The eldest son had been murdered only a year before and his killers had just been tried and sentenced. Mrs. Jackson told me that he had just seemed to hold on until the trial was over and then when it was settled, he gave up to die.

I said yes to her request without any hesitation. J.P. had always been one of my pet patients anyway. I told her that I would come out after supper.

The Jackson family is large and quite close-knit. There appeared to be a reunion in progress when we drove up to their rural Falkner, Mississippi home. My husband and two boys came along for the ride. There were plenty of kids for them to play with.

J.P. was on a day bed in his room. At 78, this formerly robust farmer and Primitive Baptist minister might have weighed 80 pounds. He was on oxygen but pitifully gasping for every breath. Sadly he was still quite lucid. He told me that he hurt terribly and prayed aloud that the Lord would be merciful and let him die soon. His chest sounded awful. He was restless, refusing food and water and was now very dehydrated. A few days earlier he had made a "living will" which precluded feeding tubes and other heroics. He told me that he didn't want an IV either, and that he wasn't about to go to the hospital. At this point I figured that he had about 24 hours to go at most. But, I felt as if I had to do something other than just come by to make a premature pronouncement of his demise.

I gave him two injections, an analgesic and a bronchodilator. I gave him something to make him rest. At that point I couldn't see that it mattered whether I depressed his respirations or not.

When he passed into a fitful sleep, I told the family to do the same. Then we shared coffee and caramel cake and reminiscences of happier days. When I got ready to leave one of the daughters gave me a wonderful still-warm chocolate layer cake. She quipped that she "knew I was coming so she baked a cake".

After a new two-hour visit with the Jacksons, they all in turn expressed sincere thanks to us and we headed for the house. I thought as we traveled home that this was the first truly satisfying thing I had done in days. This family had made me feel like a real physician again, not some drone spending my days doctoring charts instead of people. I left the Jackson home feeling as if I owed them a debt for reinfusing my self-esteem. This was the kind of medicine that I had dreamed of practicing as a dreamy-eyed med student.

Mr. Jackson died around noon the next day. The family called to tell me that the suppositories I ordered made his last hours more restful. I suppose in such cases as this we treat the family as much as we treat the patient. His wife expressed her deepest gratitude once again. She seemed to be holding up well.

At the funeral home the next day it was a major relief for me to see him looking pink and serene. We would never see J.P. struggling for breath again.

So fellow physicians, if the current state of affairs in medicine has you clinically depressed, I have a suggestion for you. Make a house call, and make it a good one. Don't make it grudgingly or hurriedly. Take time for cake and coffee with the family. Bend the rules a bit. Alleviate some suffering. Share a laugh. Tell them to call you if they need you and mean it. When your patient dies, go to the funeral home if you can. And then cry because there really was so little you could do to help him.

This procedure is guaranteed to make you feel like a real Doctor again. You will live on that wonderful feeling for days afterward.

Dwalia South, MD
Ripley, Mississippi

P. S. The CPT-code for this is 99353.



ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

AXID®
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

1. Data on file, Lilly Research Laboratories.

See accompanying page for prescribing information.

© 1991, ELI LILLY AND COMPANY

NZ-2947-B-249304

AXID®

nizatidine capsules



Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

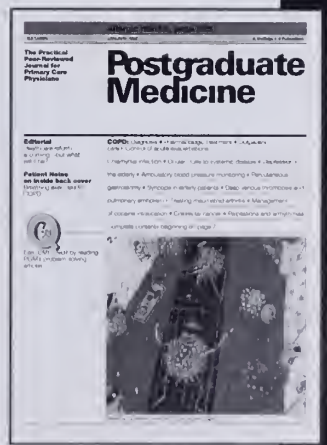
NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

US THEM







WHEN YOU NEED TIME ON YOUR SIDE, THE CHOICE IS CLEAR.

NO CLINICAL CLUTTER—PGM ARTICLES ARE CLEAR, CONCISE, WELL ILLUSTRATED, AND PRACTICAL.

Postgraduate Medicine

Medical Organization

☑ HEALTH CHOICE '92

MISSISSIPPI STATE MEDICAL ASSOCIATION AND AUXILIARY

On April 3, the Mississippi State Medical Association and the Mississippi State Medical Association Auxiliary held its second youth health seminar. This seminar, **Health Choice'92**, was held in the Union building on the Hattiesburg campus of the University of Southern Mississippi.

Approximately ninety-one students from six Mississippi Junior and Senior High schools participated in the day's activities. These students represented classes which studied the Comprehensive Health Education Curriculum of the Mississippi Department of Education. Also participating were teachers, parents, Mr. I. D. Thompson, health curriculum coordinator from the MS State Department of Education; MSMA President James C. Waites, MD; MSMA President-Elect William C. Gates, MD and his wife Linda; and MSMA Auxiliary President Sylvia Walker. The seminar was coordinated by the MSMA Auxiliary Health Projects Chairman Lynn Duncan of Pascagoula.

Health Choice'92 had a slightly different format this year and was widely approved by students, teachers and MSMA Auxiliary members as they participated in the program.

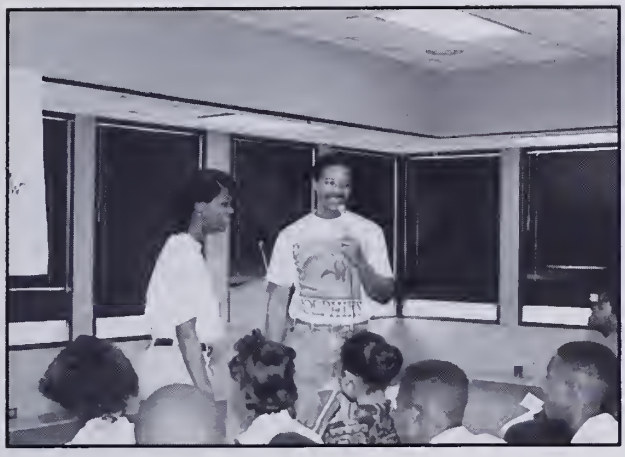
The teachers and students participating in last year's seminar gave such an excellent rating to the session's key-note speaker, JeVon Thompson, from Olympia, Washington, that he was invited back again this year.His rapport with the student audience was quickly established as he began his motivational presentation. Drawing on his own life experiences, JeVon had everyone involved with building and maintaining positive attitudes and relationships. JeVon challenged everyone to dream dreams and then work to see them happen.

Students began and ended their day with "healthy refreshments" furnished by Central Medical Society Auxiliary members and served by Auxiliary members Jane Ladner, Barbara Rushton, and Sandy Atkinson. The South Mississippi Medical Society Auxiliary furnished a very "healthy lunch" which was served by Auxiliary members Veronica Condon and Jan Howard assisted by volunteers from the local Diatetic Association. Each lunch included a written nutritional analysis of it's content.

The afternoon session began with a presentation by four members of the RAP team from Mississippi Children's Home Society, Jackson. In this instance, RAP meant talk, and these students really had something to say. Each of them told "their story" to our Health Choice audience, their peers. One member talked to the group about sexual abstinence, a second RAP team member talked about her current life as a 17 year-old unwed mother raising a 2-year old child, and the other two team members talked about the reality of AIDS and being HIV positive. Not only do these students tell their personal stories, they allow the audience to ask questions ..... any question. The team's goal is to help others learn from their mistakes so they are willing to very frankly share their personal experiences. This dialogue between the RAP team and the Health Choice participants was probably the most significant part of the day's program. Students learned from other students about the realities of just what can happen in life. The Mississippi Children's Home Society RAP team speaks to groups all over our state.

All participants had the opportunity to enjoy a Health Fair. Seventeen booths were set up to provide information on subjects ranging from blood pressure to seat belt safety. Students were required to visit each booth and get their participation card checked. Drs. Nina and Ellis Moffit were on hand in the "The Doctor's In" booth to answer questions from students and adults alike. At the conclusion of the Health Fair everyone received a Health Choice'92 T-Shirt and was offered a "healthy refreshment" break before beginning their trip home.

Thanks go to the MSMA Auxiliary Health Projects Chairman Lynn Duncan and all those MSMA Auxiliary members who assisted for an excellent Health Choice'92. ❑



Keynote Speaker JeVon Thompson, right.



Health Choice'92 participants.



Health Choice'92 participants.



MS Children's Home Society RAP Team.



Lunch was served by South Mississippi Medical Society Auxiliary members.



Refreshments were served by Central Medical Society Auxiiliary members .



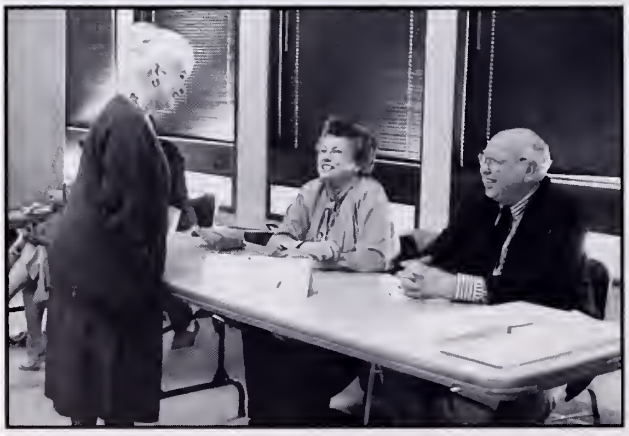




HEALTH CHOICE '92
STUDENT HEALTH FAIR









SUMMARY OF BOARD OF TRUSTEES MEETING March 28-29, 1992

The MSMA Board of Trustees held its regular Spring meeting in Laurel on March 28-29. The following Officers and Board members were in attendance; **James C. Waites, MD**, Laurel, President,; **William C. Gates, MD**, Columbus, President-Elect; **J. Elmer Nix, MD**, Jackson, Immediate Past President; **Don Q. Mitchell, MD**, Jackson, Secretary-Treasurer; **H. Vann Craig, MD**, Natchez, Speaker of the House; **Fred L. McMillan, MD**, Jackson, Chairman, Board Member, Dist. 4; **Mal G. Morgan, MD**, Natchez, Vice Chairman, Board Member, Dist. 7; **Stanley A. Wade**, MD, Meridian, Secretary, Board Member, Dist. 5; **Michael H. Carter, MD**, Greenwood, Board Member, Dist. 1; **Stanley Hartness, MD**, Kosciusko, Board Member, Dist. 2; **Leonard H. Brandon, MD**, Starkville, Board Member, Dist. 3; **John Paul Lee, MD**, Forest, Board Member, Dist. 4; **Eric E. Lindstrom, MD**, Laurel, Board Member, Dist. 6; **David L. Clippinger, MD**, Gulfport, Board Member, Dist. 8; and AMA Delegate **Sidney O. Graves, MD**, Natchez.

A summary of subjects considered by the Board and actions taken follows:

* Reviewed the program for the 124th Annual Session of the association planned by the Council on Scientific Assembly and commended the Council for its work in this regard. The program includes three scientific seminars on timely medical subjects. The seminars are titled: *Parameter of Care-Their Future for Medicine*; *Challenges in Geriatrics-Aiming for Our 80s*; and *New Technology-Triumph or Trivial Pursuit?*

* Received and reviewed the annual audits for the association and its affiliated organizations. The audits were presented by Emerson, Stokes, Elliott and Harper, CPAs. The association's and its affiliated organization's operations for 1991 were reported in conformity with generally accepted accounting principles.

* Voted to urge the House of Delegates to authorize a $25 MSMA dues increase effective in 1993. The Board noted that MSMA member dues had been raised a total of $85 since 1978 (from $200 to $285) and that the recommended dues increase, if authorized, would still place MSMA annual dues below average state medical association dues of $400 in 1991.

* Recognized and commended members of the MSMA Auxiliary for organizing the second annual *Health Choice 92* program for Mississippi school children and faculty. The program conducted at the University of Southern MS on April 3 featured a health fair and speakers on health education subjects.

* Heard a report from the chairman of the Board of Directors of the MS Foundation for Medical Care (MFMC) on its operations and stated support for efforts by the MFMC to oppose national regionalization of PRO data processing activities.

* Reviewed proposed regulations by the MS Board of Medical Licensure dealing with transmission of HBV/HIV to patients and went on record to urge the Board of Medical Licensure to follow widely recognized scientific evidence in promulgating such regulations.

* Received a report on annual operations of the *CommuniCare* program established to support the association's peer review activities. CommuniCare received and responded to a total of 147 inquiries from patients in 1991.

* Heard a report from the chairman of the Council on Legislation on the current status of health legislation before the 1992 Regular Session of the MS Legislature.

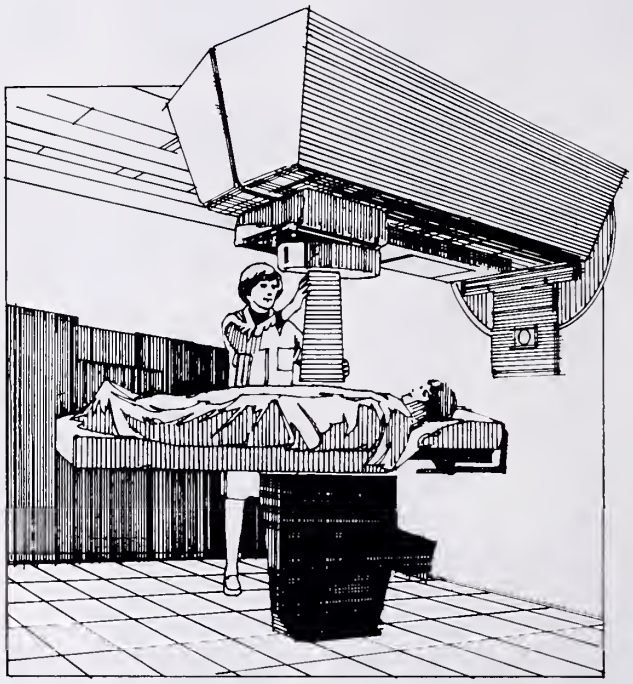
* Reviewed and approved annual reports to the House of Delegates to include: MSMA Operations/Followup on Actions by House of Delegates; Scheduling of Future Annual Sessions; MSMA Strategic Plan; Amendment to MSMA Constitution and Bylaws; and Annual Audit.

* Requested the MSMA past presidents to join the Board and current MSMA Officers in a membership recruitment and retention program for 1992.

* Heard a report on new efforts by the association to support recruitment, training and placement of primary care specialists. ❑

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

From the University of Mississippi Medical Center

Dr. Evers Transfered to Rehabilitation Center

Dr. Carl Evers, injured in a bicycle accident March 8, has been transferred to the Mississippi Methodist Rehabilitation Center for rehabilitation therapy.

Dr. Evers, associate dean for academic affairs in the School of Medicine at the University of Mississippi Medical Center, had been a patient at the University Hospital since the accident. He is a past president of the Mississippi State Medical Association and a members of the American Medical Association's (AMA) Council on Medical Education.

His neurosurgeon at the University Hospital, Dr. Lon Alexander, said Dr. Evers had a right sided acute subdural hematoma and a large left temporal lobe hemorrhage -- a condition that is 90 percent fatal. He has had three surgeries to remove blood clots, was in a coma for two weeks, and is now "showing gradual improvement," Dr. Alexander Said.

Although details of the accident are unknown, Dr. Alexander said there was no indication that his patient had been hit by a car. The bicycle he was riding was not motorized, Mrs. Evers pointed out, and he was not wearing a helmet.

Dr. Evers served as MSMA president in 1979. Other association assignments have been member of the board of directors, speaker of the House of Delegates, chairman of the Council on Medical Education and member of the board of the Mississippi Physicians Insurance Company. He has been a Mississippi delegate to AMA since 1986 and a member of the Section on Medical Schools since 1972. ❑

Study Participants Needed

Participants are needed for studies at the University of Mississippi Medical Center designed to tell whether surgery (endarterectomy) or medical treatment is more effective in preventing stroke.

Dr. Robert Smith, chairman of neurosurgery, and Dr. Robert Rhodes, chairman of surgery, are co-investigators for the Medical Center's participation in these multi-center NIH sponsored projects.

One study, the North American Symptomatic Carotid Endarterectomy Trial, has already proven that patients who exhibit symptoms and who have a greater than 70 percent obstruction (measured by luminal diameter) in the carotid artery have a 25-30 percent greater incidence of stroke when treated medically rather than surgically.

What remains to be proven is whether medical treatment or surgery is more effective in preventing strokes in symptomatic patients with more moderate stenosis (30-65 percent) or in patients with severe and moderate stenosis who have no symptoms at all. (The Asymptomatic carotid Atherosclerosis Study)

Physicians who think they may have patients who would like to enroll should call Dr. Smith at 984-5700 or Robin Brown, study coordinator, at 984-5724. ❑

Clinical Pharmacists Study New Drug

University of Mississippi clinical pharmacists are participating in a nationwide study of a new drug treatment for generalized anxiety disorder (GAD) -- one of the most common forms of severe anxiety.

Dr. Brian Crabtree, assistant professor of clinical pharmacy practice on the University of Mississippi Medical Center campus, and Dr. Andrew Bishop, a Jackson psychiatrist and adjunct assistant professor, are directing the Mississippi portion of the multi-center project.

GAD is characterized by an overwhelming and persistent mood unrelated to any other physical or

mental illness which lasts for several months. GAD sufferers typically worry about events that are unlikely to occur and have exaggerated fears about life situations. Some of the physical symptoms include dizziness, dry mouth, trembling, nausea, palpitations and muscle tension as well as irritability and difficulty sleeping.

A new drug is being tested which has fewer side effects than the benzodiazepines which are typically used in conjunction with counseling.

Physicians who have patients they think could benefit from participating in the study are asked to call or have their patients call 1-800-221-1923 or 984-2620 in the Jackson area.

Men and women between 18 and 65 who are interested in participating will be asked a series of questions to determine their eligibility. Participants receive all study medications as well as psychological and medical evaluations free of charge for the duration of the study. ❑

UMC HIV Clinic

The Division of Infectious Diseases in the School of Medicine at the University of Mississippi Medical Center directs a clinic for patients infected with the human immunodeficiency virus (HIV). The clinic is staffed by physicians and nurses as well as members of the departments of social work, dietetics, and psychology. A support group for HIV-infected patients, their family and friends meets on a weekly basis in conjunction with the clinic. Referrals to the clinic are accepted from anywhere in Mississippi, and inquiries should be directed to Dr. Harold Henderson at 984-5556. ❑

THE DELTA REGION AIDS EDUCATION AND TRAINING CENTER grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN,
Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street,
Jackson, MS 39216-4505



DOCTORS' DAY OBSERVED
Members of the Department of Anesthesiology at UMC planted a tree near the acute services wing on March 30 in observance of Doctor's Day, 1992. This year, the day marks the 150th anniversary of Dr. Crawford Long's first use of ether anesthesia for surgery in Jefferson, Georgia, on March 30, 1842. Dr. Eichhorn, right, is chairman of anesthesiology. Dr. Norman Nelson, second right, is UMC vice chancellor. Others who participated in the ceremony were Dr. Patricia Norman, associate professor of anesthesiology, and Dr. Curtis Caine, clinical assistant professor. Members of the UMC anesthesiology department attended the ceremony.



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

IT TOOK YOU MANY YEARS TO BECOME A PHYSICIAN...

MPIC

Mississippi State Medical Association Sponsored Insurance Plans

Why spend one more minute looking for LIFE INSURANCE?

The Mississippi State Medical Association, Manhattan National Life, and BellMED Insurance Resource Center Inc., have joined together to offer MSMA endorsed SIMPLIFIED ISSUE Term Life plans. Our current SUPERSAVER XV long term, low cost plan offers MSMA members, their staff and spouses these benefits...

★ **GUARANTEES**

— In these days of economic and financial uncertainty, we are pleased to offer you a 15 YEAR RATE GUARANTEE

— Your premium stays level and cannot be increased for the next 15 years...and that's guaranteed

— The coverage is guaranteed renewable to age 95

★ **SIMPLIFIED ISSUE**

— NO EXAM or BLOODWORK*

— NO SALESPERSON VISIT

— ONE PAGE APPLICATION

★ **VERY LOW RATES**

— example: $200,000 preferred non-smoker — annual rate guaranteed for 15 years

Age 40	=	**$400**
Age 45	=	**$554**
Age 50	=	**$800**

IF YOU HAVE ALREADY TAKEN ADVANTAGE OF THE PROGRAM...*THANK YOU!*

BELLMED

If you have not, we think SIMPLIFIED ISSUE SuperSaver XV makes sense. For rates and information, call BellMED at

1-800-456-8042

Manhattan National Life

*Manhattan National Life does reserve the right to request additional information.

Personals

Tim Alford of Kosciusko was the recipient of the Kosciusko Lions Club Outstanding Citizen award for 1991.

William A Causey has been elected chief of staff of the medical staff of St. Dominic-Jackson Memorial Hospital, to serve during 1992-923.

Carolyn Gerald of Wiggins has been certified as a Diplomat of the American Board of Emergency Medicine.

Robert R. Herrington, III of Hattiesburg was recently re-elected as a director of the Mississippi Academy of Family Physicians for District I.

Julian B. Hill, of Oxford has been named clinical instructor of the Department of Pharmacy Practice, School of Pharmacy, Univeristy of Mississippi.

Catherine P. Hirsch of Pascagoula announces the relocation of her Pascagoula office to 2810 Andrew Avenue, Pascagoula.

Mark Horne of Laurel has joined the staff of the Internal Medicine Clinic of Laurel. He has recently completed a residency program in internal medicine at Erlanger Medical Center in Chattanooga, TN.

Diane Little of Hattiesburg recently spoke on *The Wonder Years? Dealing with Adolescents* at Pine Grove Counseling Center in Laurel.

John E. Mann, a family practioner, has associated with **Edward L. Carruth** and the Immediate Care Clinic, 1710 14th Street, Meridian.

Phil Mathis of Oxford spoke at the Annual Meeting of the Association of Operating Roon Nurses in February, on the topic *Understanding laproscopic Appendectomies and Cholecystectomies.*

James S. McIlwain, Jr. of Clinton has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Francis Morrison of Jackson recently participated in the annual meeting of the South Central Association of Blood Banks. During this meeting he was elected President of the Board of Trustees of the South Central Foundation. This Board oversees educational funds for the association in order to advance the educational and

Physicians' Recognition Award

Six MSMA members were named recipients of the AMA Physicians' Recognition Award in March 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These six individuals are presented below by medical society.

Central
Phillip Kay Blevins, MD
S. Jobe Wilder, Jr, MD

Homochitto Valley
Shanti Pandey, MD

North Central
Wirt F. Shrock, MD

Northeast
Janis C. Edmonds Burns, MD

Prairie
Harmon Sidney Prosser, MD

scientific mission of the association.

Yoshinobu Namihira of Vicksburg has been certified as a diplomate of the American Board of Internal Medicine in the subspecialty of gastroenterology.

Buddy Savoie of Jackson and co-authors, **Dr. Buford Yerger and Dr. Tom Montgomery** received the *Charles Neer Award* at the American Shoulder and Elbow Surgeons Annual Meeting in Washington, DC for their study on a comparison of arthroscopic and open reconstruction of rotator cuff injuries of the shoulder.

Carol Scott-Conner of Jackson was recently appointed Mississippi State Chairman of the American College of Surgeon's Cancer Liaison Program.

Fredrick C. Shaw of Yazoo City has certified as a diplomate of the American Board of Pediatrics.

Wirt F. Shrock, Jr. of Durant has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

C. Chapman Sledge announces the opening of his medical practice of Addiction Medicine at North Mississippi Medical Center.

Stephen W. Stagg of Vicksburg has received his board certification from the American Board of Gastroenterology.

James O. Stephens of Magee has benn certified as a Diplomate of the American Board of Medical Managment.

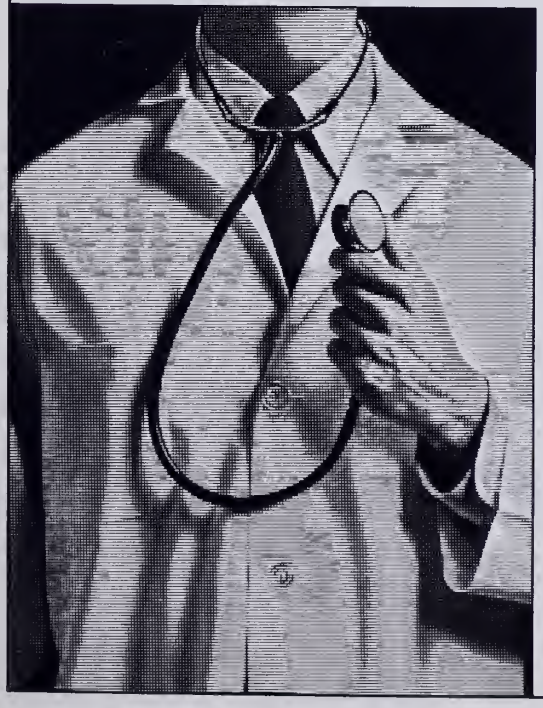
Dawn Sumrall has associated with the Southwest Clinic for Women, 300 Rawls Drive, McComb, MS.

Anita Tribble has associated with the Vicksburg Clinic in the practice of Internal Medicine.

Diego Velasco, announces the opening of his medical practice for generay surgery/colon and rectal surgery, 810 Medical Center Drive, West Point.

David F. Wender has associated with **Charles L. Knight and Mitzi Ferguson** of the practice of Neonatal-Perinatal Medicine at Woman's Hospital, Jackson.□

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect .

ARMY HEALTH CARE TEAM

(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.



RUN A SPECIAL PRACTICE.

Today's Air Force has special opportunities for qualified physicians and physician specialists. To pursue medical excellence without the overhead of a private practice, talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay each year that are part of a medical career with the Air Force. Discover how special an Air Force practice can be. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

coughing up blood
Weight Loss
POSITIVE SKIN TEST
Night Sweats
WEAKNESS
CHILLS
MALAISE
FEVER
HEMOPTYSIS
Loss of Appetite
Think
TB!
chest pains
difficult breathing
Exposure to Tuberculosis
fatigue
ANOREXIA
failure to thrive
Abnormal X-RAY
cough
Significant Skin Test
Shortness of Breath

Recognize possible signs and symptoms of Tuberculosis. Early diagnosis and treatment reduces spread. Contact your Health Department or physician for more information.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

5223 Equal opportunity in employment/services August 1989 Reprinted February 1990

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

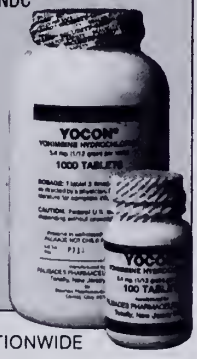
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile Impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

We earn your trust every day.℠

Trustmark™
National Bank

Jackson/Bogue Chitto/Brandon/Brookhaven/Canton/Clinton/Columbia Florence/Flowood/Georgetown/Gloster/Greenville/Greenwood/Hattiesburg Hazlehurst/Hernando/Horn Lake/Leland/Liberty/Madison/Magee/McComb Olive Branch/Pearl/Pelahatchie/Petal/Richland/Ridgeland/Southaven Tylertown/Wesson

Member FDIC

Placement Service
Physicians Wanted

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

TIRED OF WORKING FOR SOMEONE ELSE WITH NO CHANCE FOR OWNERSHIP?

Mississippi. Excellent opportunities for career-oriented Emergency Physicians. OWNERSHIP OPPORTUNITIES. Local physician-owned and managed group with contracts in North, Central, and Southcentral Mississippi with potential income of $200,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Positions available now. Please send your CV to P.O. Box 13849, Jackson, MS 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

SOUTHEAST; GENERAL SURGERY-Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice w/ coverage from surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician $150,000 net before taxes for 2 years. Richard Glehan 800-221-4762.

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119

MEA

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

TIRED OF NIGHT CALL AND ADMINISTRATIVE BURDENS?

Mississippi. An incredible practice is now available within a progressive, established group of Family and Industrial Medicine Physicians. No hospital call. OWNERSHIP OPPORTUNITIES in this expanding Episodic Care and Industrial Medicine Clinic system. Potential income of $150,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Have a busy practice from day one, with extremely high, long-term income potential. Please send you CV to P.O. Box 13849, Jackson, Mississippi 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

Family Practice/ ER Physician needed on a regular weekday basis (15 to 20 hours a week) and to work alternate Saturday's. North East Jackson. Call 957-2273.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Classified

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captian Mike McRaney, (601) 875-946, PO Box 999, Biloxi, MS.**

FOR SALE: Tingle TXR 9 Radiographic unit. General practice with Flat Bucky table. Less than 2 years old. For more information call (601) 762-3664.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

Items for the
Placement Service
should be sent to the Editors,
***Journal MSMA*,**
PO Box 5229,
Jackson, MS 39296-5229.

Index to Advertisers

CancerPay Plus 190

Deposit Guaranty Investments 191
Disability Determination 200
Doctors Insurance Reciprocal 194

Eli Lilly & Co. ..... 184 & 185
Employer Plus, Inc. 175

Harreld Chevrolet-Oldsmobile 174

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 177
MS Emergency Association 201
MS Methodist Rehabilitation Center.. **second cover**
MS Physicians Insurance Company 7
MSMA Benefit Plan & Trust 6
MSMA Sponsored Insurance Plan 195

Palisades Pharmaceuticals 199
Parke Davis ..... **insert**
Post Graduate Medicine 185
Premier Printing 199

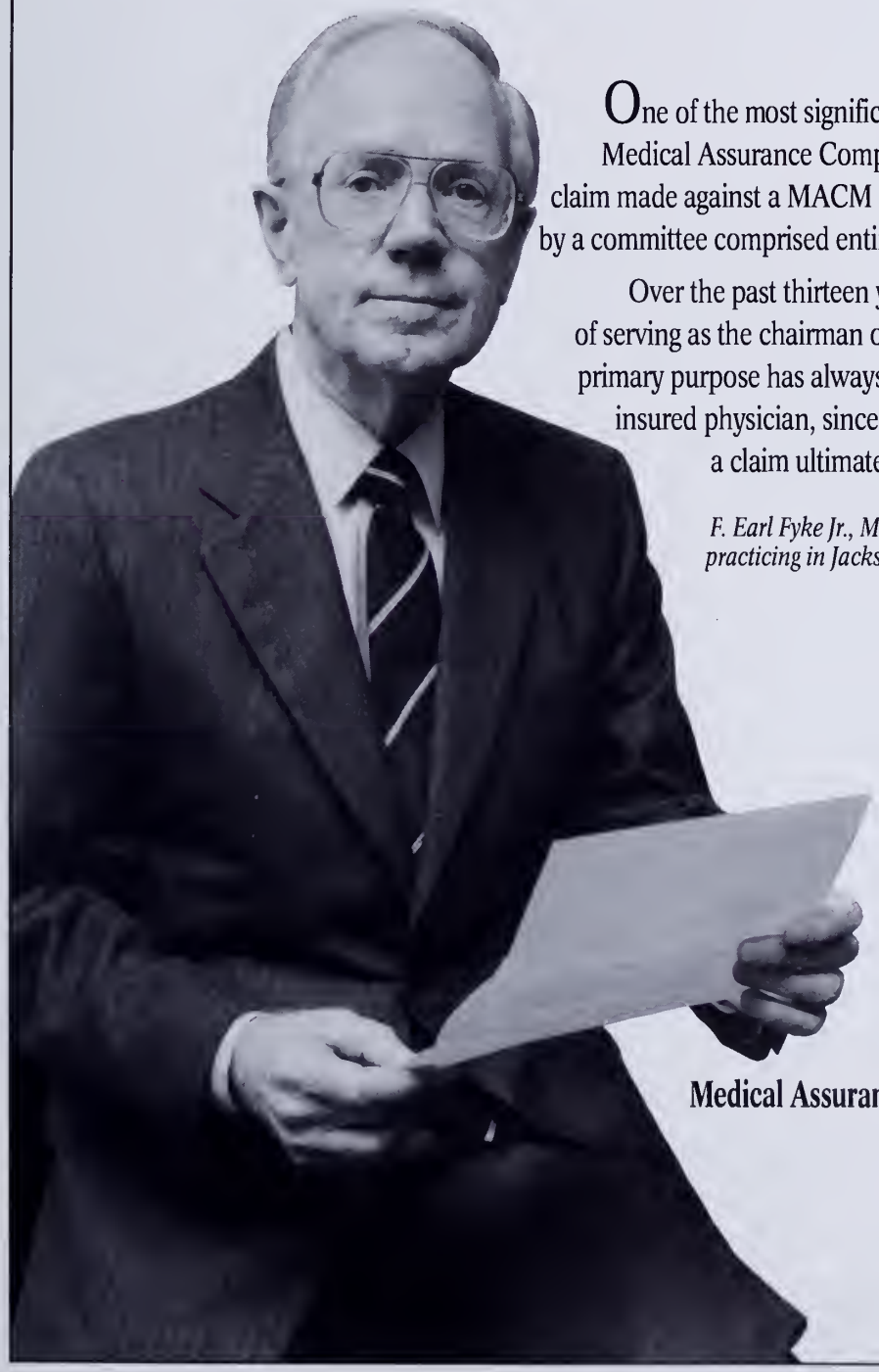
Searle ..... **fourth cover**
St. Stanislaus 8

The Doctors' Company 4
Trustmark 199

US Air Force 198
US Air Force Reserve 174
US Army Active 197
US Army Reserve 170

Jon Wimbish 169

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

For the many faces of mild hypertension

#1 MILD



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION[1]*

- Effective 24-hour control[2]
- Single-agent efficacy
- Well tolerated†
- No adverse effects on total cholesterol, plasma glucose levels, renal function,‡ or serum electrolytes[3-6]

LIBRARY
MAY 20 1992
N.Y. Academy of Medicine

ONCE-DAILY
Calan® SR
verapamil HCl
180 mg
SUSTAINED-RELEASE CAPLETS 240 mg

For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:102S-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumongenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific Information Department
4901 Searle Parkway
Skokie, IL 60077

© 1992 Searle

A92CA6694T

SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JUNE 1992





you mean this is what I've been training for all my life?



He trains year-round on the weights and on the track. But it wasn't long ago when he thought the race was over.

A diving injury had left Sammy Shute a quadriplegic. That's tragic news for anyone, but especially someone like Sammy who's been an athlete all his life.

With a whole new set of issues to come to grips with in his life, Sammy found the strength he needed in the therapy at MMRC.

"I looked at therapy as competition," he said. "To do something better than I'd done it before. I guess you could say I was in competition with myself."

Over time, the staff helped him realize that by giving 110 percent every day, there was a multitude of things a person could do in a wheelchair. Like racing, for example. He went on to become an inspiration not only to others, but to the very people who'd been such an inspiration to him.

It's that one-on-one relationship between patients and staff that makes MMRC the South's leading rehabilitation center. If you don't believe it, come out to the races one day. You'll see the proud results from start to finish.

MMRC
MISSISSIPPI METHODIST
REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JUNE 1992 VOLUME XXXIII NUMBER 6

SCIENTIFIC ARTICLES

Laser Applications in the Lower Genital Tract 203
Michael D. Fox, MD; Ramon P. McGehee, MD; Bryan D. Cowan, MD and G. Rodney Meeks, MD

Traumatic Neuropathic Spinal Arthropathy 209
Thomas J. Montgomery, MD and Robert A. McQuire, MD

SPECIAL ARTICLE

Address of the President 213

EDITORIALS

"He went off and made a doctor..." 216
William C. Gates, MD

Medical Ethics and Medical Technology 217
George E. Abraham, II, MD

DEPARTMENTS

Letters 218
124th Annual Session Highlights 220
Medical Organization 229
New Members 232
Deaths 234
Personals 237
Placement Service 241

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD,
Chairman
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
William C. Gates, MD
President
Don Q. Mitchell, MD
President-Elect
D. Stanley Hartness, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.


WE'RE ALWAYS
ON CALL.
1-800-352-2226
Call the travel specialists toll-free!
When you come down with the urge or necessity to travel, call Avanti for expert service. Everything we do for you is free of charge, even the phone call.
Our travel specialists will take care of all your plans, plane reservations, car rental, hotel accommodations and much more. We're here to help you with charters, tours, cruises, personal vacations, business meetings and conventions.
The next time you make travel arrangements, remember Avanti is always on call, toll-free.
TRAVEL, INC.
Three Lakeland Circle • Jackson, Mississippi 39216 • 981-9111
Call Toll-Free Nationwide 1-800-327-4236

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 6

June 1992

Dear Doctor:

Participants are needed for the Breast Cancer Prevention Trial, the most significant prevention study the National Cancer Institute has sponsored. Jackson Oncology Associates, a partner in the Ochsner Community Oncology Program, is helping to recruit some of the 16,000 women needed nationwide to participate in this landmark trial.

The study will focus on Tamoxifen, a synthetic hormone already proven effective in the treatment of breast cancer. It is hoped that healthy women on Tamoxifen will have a significant decrease in the number of breast cancers as well as a decrease in osteoporosis and myocardial infarctions.

To be eligible, women ages 35 to 59 must have a definable increased risk of developing breast cancer. Some of these factors include first degree relatives with breast cancer, nulliparity, first pregnancy after age 30, early menarche, prior breast biopsies for fibrocystic disease or noninvasive cancer. The risk evaluations will be done using a modified version of a risk assessment tool created by the NCI in 1989. Since the risk of developing breast cancer increases with age, women 60 and over are eligible based on their age alone.

Physicians who need more information or who may have patients eligible for the study should call Dr. Gerry Ann Houston at Jackson Oncology Associates (355-2485). Patients may call 353-3475 and an informational packet will be sent to them.

NIAAA's Alcohol and Alcohol Problems Science Database

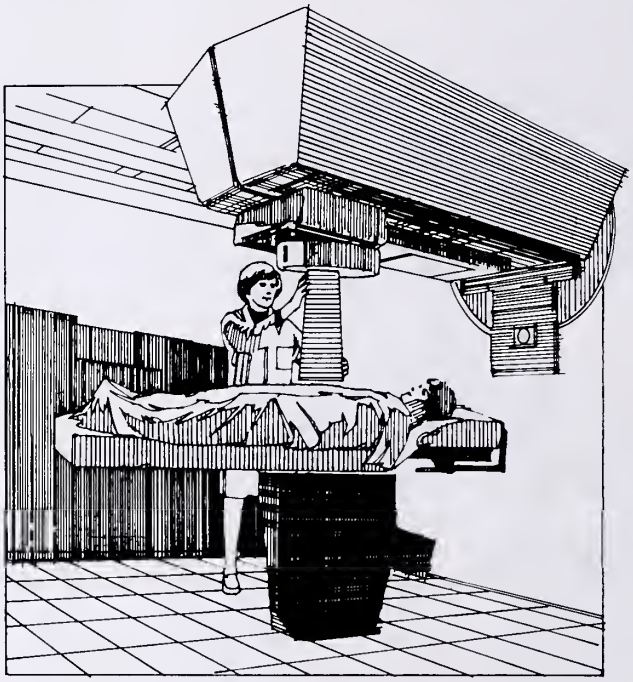
Which alcoholism-screening instruments are appropriate for which patient populations? How is alcoholism linked to various medical disorders? What are the effects of prenatal alcohol exposure? The Alcohol and Alcohol Problems Science Database, commonly knows as ETOH, quickly provides useful information on these and many other alcohol-related questions.

Produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), ETOH is the largest and most comprehensive online source of alcohol research available in the world today. ETOH is multidisciplinary, covering biomedicine, psychiatry, epidemiology, treatment, prevention, and many other fields. ETOH records are derived from a variety of sources, including journal articles, government reports, conference papers and proceedings, dissertations, books, and chapters in edited works. Because of its broad subject scope and diverse sources, ETOH offers searchers a complete perspective of the world of alcohol research.

Dating from the late 1960's, ETOH contains over 75,000 records, each of which contains an abstract and relevant bibliographic information. Users can search ETOH by subject, author, title, source, or year. One can request a search through a library, information center or if you have a computer and modem by subscribing to BRS at 1-800-995-0906. For more information about ETOH, contact the Office of Scientific Affairs, National Institute on Alcohol Abuse and Alcoholism, 5600 Fishers Lane, Room 16C-14, Rockville, MD. 20857.

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

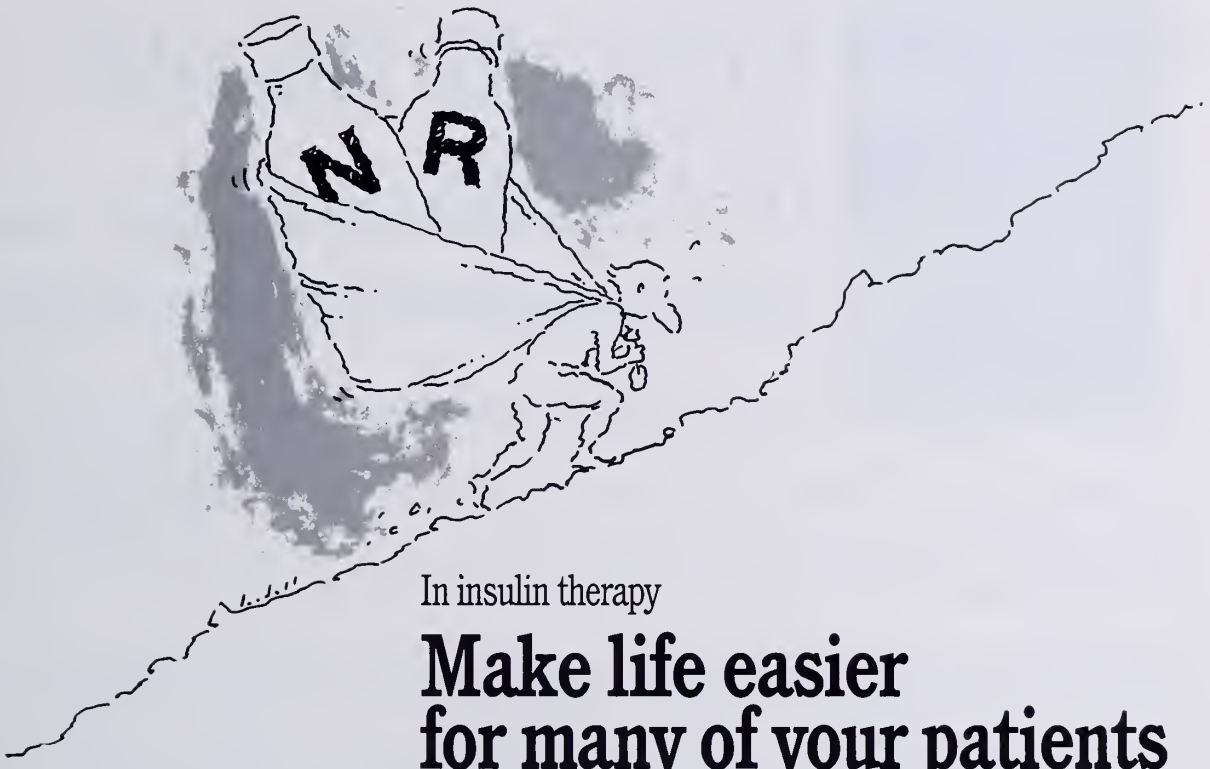
"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251



In insulin therapy

Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer. No more mixing. No more mixing errors. All of which makes living with diabetes a little easier for patients. And compliance a lot easier to achieve.



Humulin® 70/30

70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

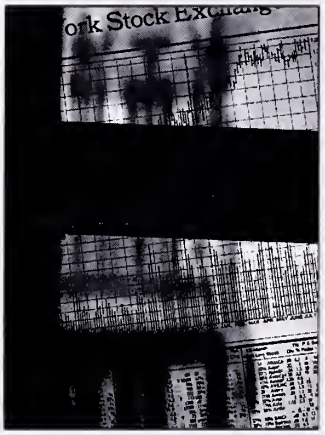
The patient-friendly premix

Global Excellence in Diabetes Care

Eli Lilly and Company
Indianapolis, Indiana
46285

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

HI-7905-B-249327 ©1992, ELI LILLY AND COMPANY



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

Laser Applications in the Lower Genital Tract

MICHAEL D. FOX, MD
RAMON P. MCGEHEE, MD
BRYAN D. COWAN, MD
G. RODNEY MEEKS, MD

The acronym "LASER" stands for Light Amplification by Stimulated Emission of Radiation. Laser physics is based on Planck's quantum theory of light, Bohr's description of atomic orbitals and Einstein's theory of stimulated emission. Laser light has three unique qualities. Each laser medium emits monochromatic light of a unique single frequency. The light waves are coherent, so that the peak and trough of each wave cycle is identically aligned. The light waves are parallel and diverge minimally. This property of collimation allows the beam to be focused to an intensity 6 million times that of white light.

During the past 15 years lasers have been studied extensively. The laser adds vaporization to the surgeon's traditional armamentarium of incision and coagulation. Gynecologically useful laser media include, CO_2, Neodymium Yttrium Aluminum Garnet (Nd:YAG), Potassium Titanyl Phosphate (KTP) and Argon. Most laser surgeons have experience with the CO_2 medium, since it is effective in all gynecologic applications except hysteroscopy. It is widely available, and is relatively safe to operate. Safety guidelines have been developed for each laser by manufacturers and government safety regulators. The Nd:YAG laser is ideally suited for hysteroscopic ablation of the endometrium because the beam can penetrate liquid.

The laser unit consists of three components. The energy source excites the laser medium. The resonating chamber houses the laser medium. Finally, the delivery system focuses the light beam.

The beam is delivered through a flexible fiberoptic system (Nd:YAG, Argon, KTP) or an articulated arm system ($C0_2$). Flexible fiberoptics utilize crystal tips to focus the beam. Conversely, the articulating arm is hollow and uses lenses to focus the beam via either a handpiece or an operating microscope. The fiberoptic systems are less cumbersome than the CO_2 laser articulated arm but offer no other advantage.

Laser-tissue interaction can be described in terms of tissue absorption, tissue reaction, and power density. Tissue absorption is dependent on laser light wavelength. Water absorbs the majority of the $C0_2$ laser beam energy which accounts for shallow tissue destruction. Because of the high percentage of water in tissues, the CO_2 laser is effective in most tissues. The Nd:YAG laser is absorbed by melanin and hemoglobin and therefore is useful in blood rich tissues, such as the endometrium. The Argon and the KTP lasers are predominately absorbed by hemoglobin and darkly pigmented tissue and are most useful in treating endometriosis. Because the Argon, KTP and Nd:YAG are poorly absorbed by water, they can be submerged as required with hysteroscopy. Approximate depths of absorption are 1 mm for the CO_2, 6-30 mm for the Nd:YAG and 4 mm for the Argon. The deeper penetration of the Nd:YAG laser also aides with endometrial ablation.

Tissue reaction consist of vaporization, coagulation, and thermal

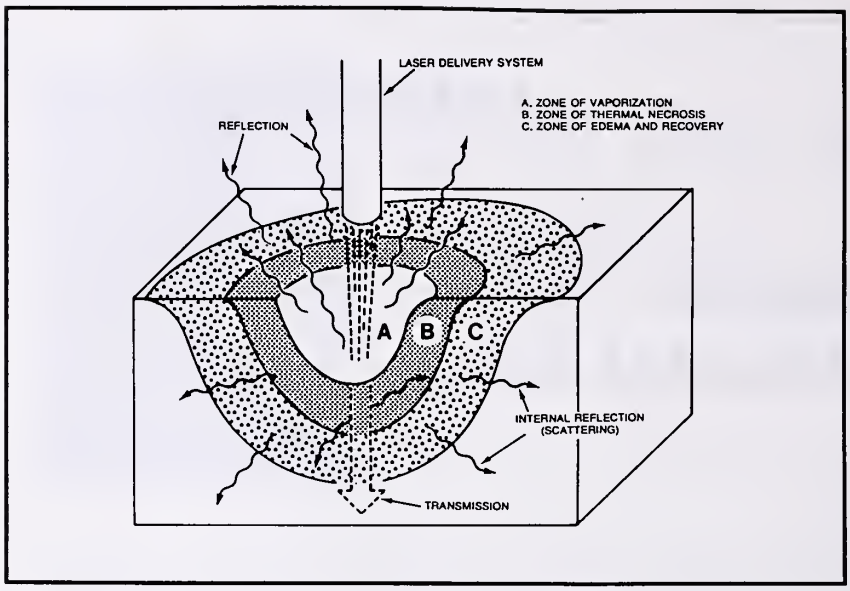


***Figure 1** - Anatomy of a laser crater. Reproduced with permission from Laser Surgery in Gynecology and Obstetrics (2nd ed.) William R. Keye, Jr., MD, Year Book Medical Publishers, INc., Chicago, p. 29.*

stimulation. All three are present in each laser crater (Figure 1). Vaporization with minimal coagulation is the primary effect of the CO_2 laser while the reverse is true for Nd:YAG and KTP lasers. Power density (PD) between 10-150 w/cm^2 produces nearly pure coagulation, whereas PD in excess of 750 w/cm^2 largely produces vaporization. In the interval range a combination of slow vaporization and coagulation occurs. However, high crater temperatures may produce a great deal of unwanted tissue necrosis below the laser crater. Thermal stimulation and diminution of coincident adjacent tissue damage may explain decreased surgical morbidity and improved tissue regeneration which are touted as significant advantages.

A focused laser reaches the target exactly at the focal point of the lens, which results in the smallest obtainable spot size. As the laser is pulled away from the target (defocused) the spot size enlarges and PD is proportionally decreased. Specifications of focal length and spot size for a particular laser can generally be found in the operators manual. For the CO_2 laser, the end of the handpiece guard is the focal length. When the handpiece is used, small variations in target distance can change PD from a vaporization range to a coagulation range. This is contrasted with the microscope or colposcope where spot size, and thus PD can be set and be maintained accurately. With powerful lasers spot diameter can be increased to 2 mm or more and maintain sufficient PD for vaporization. The rate of tissue vaporization is directly related to PD.

The laser beam may be delivered as continuous, interrupted, or superpulse wave form. Superpulse mode allows energy to be stored and released in short bursts of power which are higher than possible in continuous mode. The on/off time ration is 1:10. The tissue can cool between laser bursts thus decreasing coagulation. The limitation of superpulse mode is that average power output is reduced by more than 50% when compared to continuous mode. Therefore, superpulse is impractical for a large volume of tissue ablation. It is, however, useful when it is necessary to remove small amounts of tissue from underlying vital structures such as ureter, vessels, or bowel. Interrupted mode is a compromise. On/off ratio is approximately 1:1. Average power is maintained and peak power output is higher than continuous

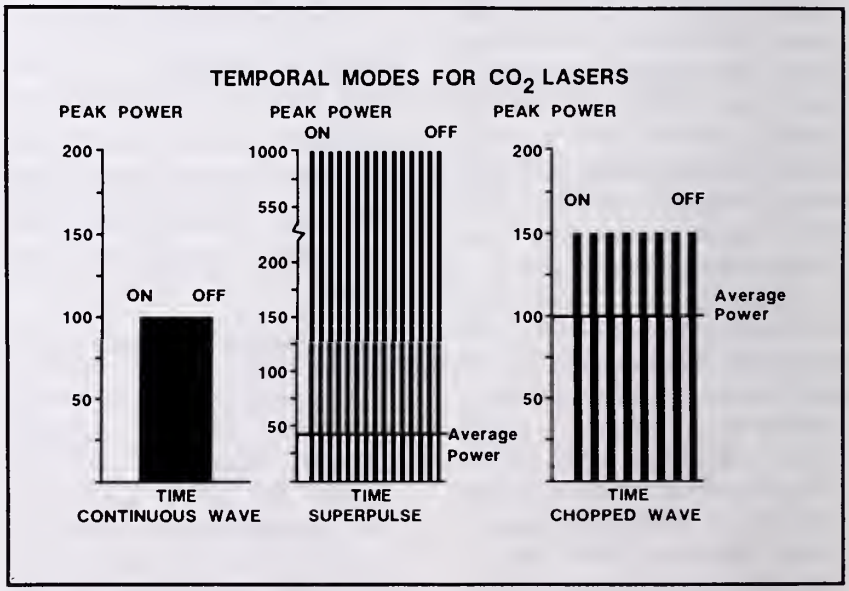


***Figure 2** - Power difference between continuous wave, superpulse wave, and interrupted wave laser beam. Reproduced with permission from Obstetrics and Gynecology Clinics of North America, 1987;14:520, R. Reid, Physical and surgical principles governing expertise with the carbon dioxide laser.*

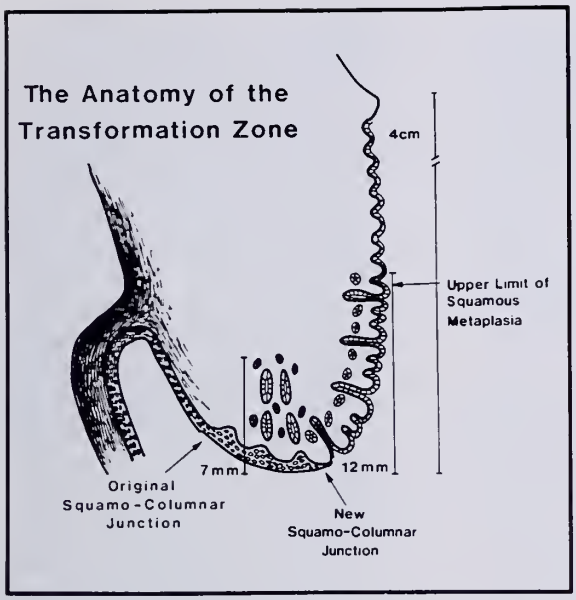


Figure 3 - Anatomy of the transformation zone. Reproduced with permission from Obstetrics and Gynecology Clinics of North America, 1987; 14:526, R. Reid, Physical and surgical principles governing expertise with the carbon dioxide laser.

mode (Figure 2). This then is the most desirable mode for ablative applications.

Laser surgery is most advantageous in Cervical Intraepithelial Neoplasia (CIN) and Vulvar Intraepithelial neoplasia (VIN). Laser treatment options for CIN include: lesion ablation, cervical ablation of transformation zone, cervical conization, and combination cone/ablation. A thorough understanding of cervical anatomy and the transformation zone is necessary before undertaking ablation of cervical dysplasia. The transformation zone starts on the portio cervix at the original squamocolumnar junction and extends toward the endometrium to the proximal extent of squamous metaplasia (Figure 3). Laterally glands may extend as deep as 7 mm beneath the surface and centrally squamous metaplasia may extend 10-12 mm into the cervical canal.

Adequate colposcopy which demonstrates a lesion(s) confined to the ectocervix is a prerequisite for cervical ablation. The cylindrical-dome shaped crater is commonly used for ablation with the depth of 10 mm centrally and 7 mm peripherally (Figure 4). Laser cone specimens are at least 50% smaller than cold knife cone specimens. The endocervical depth of the laser cone is 15-18 mm as opposed to 27 mm for the conventional cone. With experience laser cones may take only 6-8 minutes and may be performed under local anesthesia in the office setting. After performing colposcopy, a dotted outline is made approximately 5-7.5 mm away from the external os using the interrupted mode. These dots are connected and taken to the desired depth. Hooks are used to expose the incision line. A spot size of 0.5 mm or less minimizes tissue loss at the incision and reduces thermal artifact at the margin to less than 0.1 mm. The base of the specimen is incised with a scalpel or scissors. A combination ablation/cone procedure offers an effective way to treat large ectocervical lesions that extend high into the cervical canal. A laser cone is performed first for diagnosis and treatment of the colposcopically inadequate endocervical lesion. This is followed by ablation of the remaining ectocervix based on colposcopic biopsies. Improper technique may allow excessive heat accumulation, unsuspected thermal coagulation below the crater and significant loss of cervical volume. Vessels less than 0.5 mm in diameter will be sealed by PD that is required for vaporization. Dilute vasopressin may be injected to constrict vessels into this range. Depth measurements may be easily made with a wooden Q-tip marked for various depths or with an especially designed sound.

Vulvar intraepithelial neoplasia is a multifocal disease and historically has been treated by skinning vulvectomy. Vulvectomy often required skin grafting and significantly altered the appearance of the vulva. The CO_2 laser offers an excellent alternative because it allows rapid healing and because it is perfectly

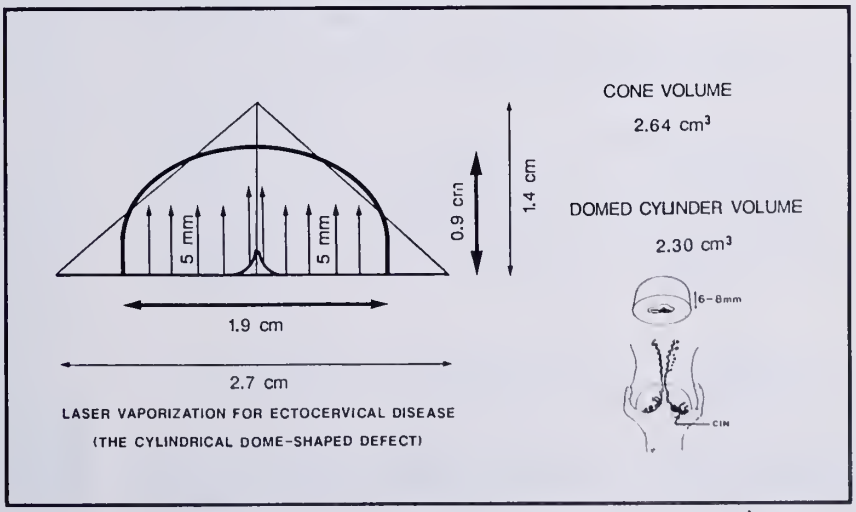


Figure 4 - The geometry of CIN for ectocervical disease. To eradicate the disease, the vaporized cylindrical dome shaped defect removes less volume than a cone shaped defect. Reproduced with permission from Comprehensive Therapy 1988;14:57. V.C. Wright, Carbon dioxide laser surgery for the cervix and vagina: indications, complications, and results.

suited to the removal of superficial disease. The operating microscope or the handpiece may be used to move the beam in a concentric, circular fashion. While depth measurement is difficult because the edges are ill defined, vaporization should be at least 2 mm. In hair covered areas where dysplasia may extend into hair follicles and appendages depth should be guided by pathology results. Four surgical "planes" have been described which allow the surgeon to visually determine the depth of ablation (Table 1). In most cases healing occurs rapidly over one to two weeks for planes 1 and 2. Healing time may be prolonged and skin grafting may be required for planes 3 and 4.

Condyloma are effectively treated with the CO_2 laser in 80-90% of patients. The human papilloma virus is destroyed at 100° C which is the minimal temperature range associated with vaporization. The virus is confined to the prickle cell layer of the epidermis. A maximum depth of 2-2.5 mm is required for effective treatment yet allows rapid healing. Since condyloma are relatively vascular, an intermediate PD (200-600 w/cm_2) is used to increase coagulation. Ablation of the lesions should be performed form outside edge to the center. Large lesions may be incised using high PD at the interface between the skin and the lesion followed by ablation of the base. Recurrence may be reduced by "painting" (using low power densities) approximately 5 mm beyond each lesion.

Endometrial laser ablation is probably not on the whole as good as cautery resection/ablation. The laser procedure requires Nd:YAG or KTP laser. For most gynecological laser surgeons, this means buying a second system. The laser procedure often takes twice as long, thus allowing for more absorption of distention media. Moreover, by destroying the endometrium there is no pathology specimen. Most importantly the laser offers no improvement in success rates.

This article has attempted to provide an overview of gynecologic laser surgery of the lower genital tract. Successful laser surgery is closely correlated with operator skill, selection of the proper laser medium, and an understanding of laser mechanics. Despite their high cost, lasers are now common in surgery suites. Developments are underway, which will make lasers less expensive and easier to use. Driven by heavy media exposure, patients often request laser surgery. The recent introduction of large loop electroexcision of the transformation zone (LLETZ) has fueled a debate over whether laser or electrocautery is preferred to excise lesions and perform cone biopsies. A through understanding of cervix anatomy is necessary for either mode of therapy. When the debate is concluded, one of these techniques may then become standard for treatment of CIN. ❑

2500 North State Street
Jackson, MS 39216-4505

References

1. Baggish MS. A comparison between laser excisional conization and laser vaporization for the treatment of cervical intraepithelial neoplasia. *Am J Obstet Gynecol* 1986;155:39-44.

TABLE 1 - FEATURES OF THE FOUR LASER SURGICAL PLANES

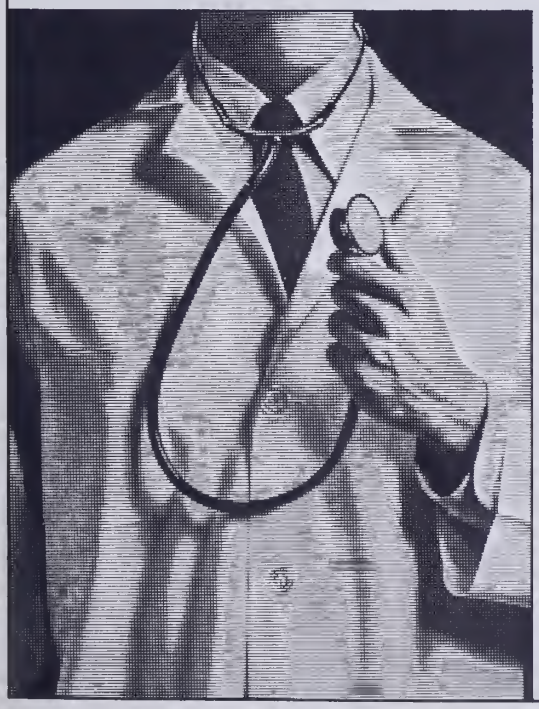
	SURGICAL PLANE			
Parameter	**First**	**Second**	**Third**	**Fourth**
Zone of vaporization	proliferating layer	Superficial papillary dermis	Midreticular	Deep reticular
Type of healing	rapid, cosmetic	rapid, cosmetic	usually cosmetic may hypertrophy	often needs grafting
Visual appearance	opalescent cell debris	scorched basement membrane "Chamois cloth"	coarse collagen fibers	"sand grains" (skin appendages)

Adapted from Reid R: Physical and surgical principles governing expertise with the carbon dioxide laser. Obstetrics and Gynecology Clinics of North America 1987;14:528.

2. Bruhat MA, Wattiez A, Mage G, Pouly JI, Cania M. CO2 laser laparoscopy. *Bailliere's Clin Cbstet Gynecol* 1989;3:487-97.
3. Daniell JF. Fiberoptic laser laparoscopy. *Bailliere's Clin Obstet Gynecol* 1989;3:545-62.
4. Donnez J, Nisolle M. CO2 laser laparoscopic surgery. *Bailliere's Clin Obstet Gynecol* 1989:3:525-43.
5. Hill D. Treatment of Menorrhagia by endometrial ablation. *Med J Austr* 1090;152:564-65.
6. Loffer FD. Laser ablation of the endometrium. *Obstet Gynecol Clin North Am* 1988;15:77-89.
7. Reid R. Physical and surgical principles governing expertise with the carbon dioxide laser. *Obstet Gynecol Clin North Am* 1987;14:513-35.
8. Riva JM, Sedlacek TV, Cunnane MF, Mangan CE. Extended carbon dioxide laser vaporization in the treatment of subclinical papillomavirus infection of the lower genital tract. *Obstet Gynecol* 1989;73:25-30.
9. Wright VC. Carbon dioxide laser surgery for the cervix and vagina: indications, complications,and results. *Comprehensive Therapy* 1988;14(11):54-64.

*From the Department of Obstetrics and Gynecology, University of Mississippi Medical Center. **Dr. Fox** is a resident in Obstetrics and Gynecology, **Dr. McGehee** is assistant professor of Obstetrics and Gynecology, **Dr. Cowan** is professor of Obstetrics and Gynecology and **Dr. Meeks** is professor of Obstetrics and Gynecology.*

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect .

ARMY HEALTH CARE TEAM

(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720

Traumatic Neuropathic Spinal Arthropathy

THOMAS J. MONTGOMERY, MD
ROBERT A. McGUIRE, MD

Jean-Martin Charcot first described this condition in 1868 and he felt it was secondary to destruction of the "trophic" centers in the central nervous system.[1] Classically, Charcot spine has been associated with tertiary syphilis, diabetes, syringomyelia, and spinal tumors. In 1978, the first reported case of spinal neuropathy attributed to trauma was reported.[5] With improvements in long-term medical care, patients with traumatic neural deficits are now living near normal life spans and this condition is likely to become more evident in the future.

PATHOPHYSIOLOGY

The primary mechanism is normal spinal motion with loss of deep sensation in the apophyseal joint which leads to a mechanical process of degeneration of the cartilage and subchondral bone. This progressively leads to incongruity, articular fracture and ultimately gross spinal instability.

Cartilage is aneural and primary damage is therefore painless. In a normally innervated apophyseal joint a reactive synovitis occurs which is perceived as pain. Normally, this pain leads to prevention of the inciting activity, subsequent muscle spasm, and prevention of further injury. In patients with sensory neuropathy, pain perception does not occur and damage continues. This ultimately results in appearance as a grossly exaggerated degenerative joint.

Ligaments lose the ability to restrain bony movements leading to fractures, inflammation, effusion, instability until finally a gross deformity or audible crepitus or "clunk" is apparent with motion. This collapse of the normal architecture and stabilizing structures of the spine allows a giant pseudarthrosis to develop.

CLINICAL PRESENTATION

These patients complain of a vague deep aching sensation in their back below the level of their neurologic injury. A history of progressive loss of sitting balance is often elicited with recurring decubitus ulcerations. Physical examination reveals an obvious kyphotic deformity and audible "clunk" with flexion and extension of the spine.

RADIOGRAPHIC PRESENTATION

Routine radiographs reveal severe juxta-articular bone destruction with decreased disc space, dense osteosclerosis, large marginal osteophytes and bony debris.[2] This may be noted at a single level or over multiple levels, new bone formation, and effusion leads to formation of a paraspinal mass.

The atrophic form is less common and manifests as bony lysis and excessive mobility with flexion-extension radiographs.

The hypertrophic variety is more common and presents with the severe bone destruction described previously.

CT scan reveals vertebral body sclerosis, disc replacement by a soft tissue mass containing bone fragments extending outside the vertebral body margins. Calcification within this paraspinal soft tissue mass, as well as the spinal canal is also evident. These changes can be seen with disk space infections, pyogenic vertebral osteomyelitis, as well as spinal tuberculosis. The MRI may be helpful if a rim of hypointensity at the junction of the abnormal disk and the adjacent vertebral bodies on both T_1 and T_2 echoes is evident. This would tend to favor a degenerative rather than an infectious process.[3]

DIAGNOSIS AND TREATMENT

Infectious etiology must be considered. A percutaneous needle biopsy can be performed to obtain tissue for culture. Aerobic, anaerobic, acid fast bacillus and fungus cultures must be obtained.

If cultures are negative and deformity is minimal, then a total contract orthosis may be considered. Great care must be used with brac-

ing techniques in individual with insensate skin as this can lead to pressure ulceration.

Improvement in spinal instrumentation has led to fixation of the spine with improved arthrodesis. Unfortunately, multilevel laminotomy has often been preformed at the time of initial injury and presents a problem in gaining adequate fixation. This problem can be solved with the use of pedicle fixation, but one must use great care in insertion to prevent vertebral body penetration anteriorly resulting in vascular injury. Longer constructs are often necessary to provide the mechanical advantage to negate the bending forces acting upon the grossly unstable spine. Stability can be enhanced with an anterior approach and resection of the pseudarthrosis with fibular or rib strut grafting.[4]

Postoperatively, immobilization is accomplished with a total contact orthosis for 4-5 months. The brace may be removed with the patient is recumbent, but should be used when sitting or with transfers. The results with surgical treatment have been generally good with this technique as opposed to earlier technique without internal fixation.

SUMMARY

Traumatic spinal neuropathy is a condition which results as a loss of the feedback response from the insensate spine. Clinically a severe kyphotic deformity and gross instability is apparent. Radiographically, severe joint destruction with a "ball and socket" pseudarthrosis is seen. An infectious process must be excluded and surgical stabiliation has an excellent prognosis. ❑

2500 North State Street
Jackson, MS 39216-4505

REFERENCES

1. Charcot JM. Sur guelques arthropathies qui paraissent dependre d'une lesion du cerveau on de la moelle epiniere. *Arch Physiol Norm Path* 1868;1:161-178.
2. Feldman F, Johnson AM, Walter JF. Acute axial neuroarthropathy, *Radiology* 1974;111:1-16.
3. Kapila A, Lines M. Neuropathic spinal arthropathy: CT and MR findings. *J Comput Assist Tomogr* 1987;11:736-739.
4. McBride G, Greenberg D. Treatment fo charcto spinal arthropathy following traumatic paraplegia. *J Spinal Disord* 1991;4:212-220.
5. Slabuagh, PB, Smith TK. Neuropathic spine after spinal cord injury. *J Bon Joint Surg* 1978;60-A:1005-1006.

Dr. McGuire is associate professor, Department of Orthopaedics, at the University of Mississippi Medical Center.

ILLUSTRATIONS



***Figure 1** - Radiographs of this 31 y/o male who sustained a c_6 guadriplegia eight years prior and subsequently had a posterior rhizotomy for pain reveal sclerosis of the vertebral bodies of T_{12} and L_1 with significant angular kyphosis at the thoracolumbar junciton. This gentleman was experiencing significant back pain. Exam reveals and audible "clunk" with position transfers.*



2 A



2 B

***Figure 2 A, B** - These lateral flexion-extension radiographs reveal a 25 degree angular change in sagittal rotation from flexion to extension through this segment.*



3 A

3 B



***Figure 3 A, B** - This T_1 and T_2 weighted magnetic resonance image reveals a significant erosion of the end plates with a soft tissue mass present at the thoracolumbar junction.*

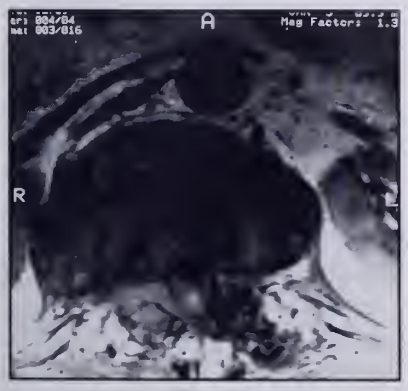


***Figure 4** - The axial view of the same area on the magnetic resonance imaging reveals loss of bony architecture with significant soft tissue mass projecting laterally for several centimeters around the vertebral body.*



5 A



5 B

***Figure 5 A, B** - AP and lateral radiograph following a simultaneous anterior and posterior surgical procedure reveals correction of the kyphosis with stabilization of the Charcot joint anteriorly using a stacked rib strut. Protection of the construct posteriorly is accomplished using pedicle screws above and below. Pedicle screws were required because previous laminectomy precluded the use of laminar hooks. This gentleman was placed in a TLSO for added protection.*

The Journal of the Mississippi State Medical Association welcomes material for publication.

For information on submitting articles for publication please write or call, the Journal of the Mississippi State Medical Association, PO Box 5229, Jackson, MS, 39296-5229, (601) 353-5433 - 1-800-898-0251.

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings Up To 15 %
✔ 2. Established by Your Association	
✔ 3. Savings over what you currently are paying	
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association



JAMES C. WAITES, MD

Address of the President

Over the past 10 years I have spoken to you in several capacities. First as the Vice-Speaker of the House, then the Speaker, now as your President. On each occasion as I have addressed you, I have tried to share some of what I had on my heart, and what I saw and sensed happening to the physicians of Mississippi. I have urged you to unite in the common fight against third party intrusion, to share your knowledge with those not in this meeting, to become active in your community and to become an activist in the politics of medicine.

Looking back, I see that this has been a common theme stressed by many past presidents:

Carl Evers addressed the problem of the concerned and the unconcerned physician and asked the question "Where will you be when the lights go out on the practice of medicine as we know it today?"

Faser Triplett had us looking at the "cost" of the medicine we practice and asked the question "Are you sure in your own mind that you are providing quality medical care at reasonable cost?"

Sidney Graves discussed the "period of transition" that the profession was undergoing.

Whit Johnson tried to warn us of the threat posed by the entry of business, industry and insurance companies into the field of medicine as "for profit" competitors for patients.

Ellis Moffitt stressed the importance of costs, quality and enthusiasm when he asked the question "Why does it take a crisis to get us motivated?"

Ralph Brock made a plea for unity and discussed health manpower, access to care, medical education and financing of health care.

Joe Burnett reminded us of our obligation to participate in the political process.

Lamar Weems would have us remember the importance of "professional power" or "influence" if you prefer, and pointed out "organized medicine is a necessary mechanism for the cultivation of professional power and a principal vehicle for its expression." And that "all physicians benefit from the efforts of organized medicine."

David Steckler pointed out that "public perspective is what drives change" and "we need to take a leadership role in efforts to reduce the cost of medicine."

Edward Hill promoted the "profession's image" in the state, and led in the establishment of the program on "Comprehensive School Health Education."

Elmer Nix focused our attention on the ethics of medicine and pointed out "A good doctor must possess knowledge, but he must also possess skill and compassion." And that "We can cure patients sometimes, we can give them relief often, but hope can be given always."

Common themes - yes. Visionary - perhaps. True - absolutely. Motivational - sadly, only to a few.

Last year I shared with you some of my vision and encouraged you to catch that vision, to unleash the power of organized medicine by your enthusiasm and your active participation. This year, I sadly report, that power that I had envisioned is still in the latent and dormant stage. We have not developed a common vision, one that is needed to propel

us forward into this decade with determination and unity.

I began the year optimistically, feeling that we had the opportunity to address some common issues with the insurance industry, and with business. I rapidly came to realize that even though we had common problems, we did not have common pathways to solving those problems. It is quite obvious that the problem of cost of care is a major one; one that is bandied from one player to the other as their own peculiar problem, and not one to be solved collectively. Each organization has blamed the other to the point that we have little common ground on which to work.

Let me tell you how we have weakened our position.

As I have traveled across the state this year, it is readily apparent to me that physicians are divided into many different camps and philosophies.

I have been chided for not opposing managed care more vigorously. And then have been questioned as to when we, MSMA, were going to take a more active role in developing a managed care product for our state. I have been asked why we allowed certain pieces of legislation to pass, but when our members are called to contact their own legislators, very few respond to that call and make the effort to do so. I have been asked over and over about what we, the profession, are going to do about access to and cost of health care, but many physicians do not perceive that they, you and I, are a part of that problem, and that we must assist in its solution. To paraphrase PoGo, "We have met the enemy, and often he is us."

I am not really sure that we, as a profession, have identified what holds and bonds us together. Is it money and how to make more? That is certainly the perception that the public has. Is it the third party intrusion into our practices? No insurance company or utilization review company would admit to deliberate interference. Is it legislative issues? We, as a group, seem to be oblivious to the legislative power and process.

The real issues is what binds us together? Where do we have a common ground? Perhaps I am far too naive, but I believe our common bond is still the patient, his health and welfare. As Dr. Nix pointed out last year, the Mississippi State Medical Association was formed to advance the art and science of medicine, and to protect the public health. I truly believe that the majority of us subscribe to this charge and are in the field of medicine because we had and have a desire to help our fellow man. Financial reward should be a secondary consideration. We each had a choice about the business that we are in. We choose to be here. We could have chosen to be in business, and most would be successful. But would you be as satisfied at the end of your career? I think not.

Researching through some of the old *Journals MSMA* and *Proceedings of the MSMA House of Delegates*, and the *AMA House of Delegates*, it was interesting to read of the struggles of our predecessors in trying to improve the quality of health care in this country. In fact there were arguments over possible closure of some medical schools because they did not produce the quality physician that was thought necessary to care for the patient. Obviously, they were successful in their efforts, for today quality is not even questioned, except rarely by our own PRO. It is conceded that American medicine is a quality product.

What is not conceded, however, is our concern for and our empathy toward our patients. You and I must encourage our best students to go into medicine; then we can insist that our medical schools accept students who are not only intelligent, but also sincere, interested and compassionate.

We need more students going into primary care. Fifty of Mississippi's 82 counties do not have adequate physician coverage.

We must use the same determination that our predecessors used in addressing quality of care to address the problems of cost and access. There was much opposition to the push for quality both within and without our profession. There may be opposition to the development of quality care plans that are both cost effective and accessible. But it must be done if we are to survive as a learned, caring profession.

I propose that we establish a "Council of Past-Presidents" to study, develop and report to this House of Delegates in 1993, a plan of action for the association to address the issue of cost and access to quality health care. They have the vision, experience and decisiveness to address this issue.

Understanding our different prospectives, I would urge that we continue our efforts to develop coalitions with business, insurance, labor and senior citizens groups.

We each have common problems, we must come to an understanding of our individual concerns. To do so, however, means that we have to make some sacrifices and give up something.

Lest I be accused of being nothing but a prophet of gloom and doom, let me remind you of the

things that have been accomplished this year. We are having the first meeting of the "Women in Medicine" group at our meeting this year. This is largely the result of the efforts of Candice Keller and Nina Moffitt. Thank you, ladies.

The successful second year of the "Comprehensive Health Education" in schools project culminated with the "Health Choice 92" seminar at USM. This was led by Lynn Duncan, Dr. Ginny Crawford, Sylvia Walker and the Auxiliary.

Through the efforts of the Council on Medical Service and our staff, Charlie, Bill and Jackye, the Medicare Advisory Committee is meeting with Travelers Medicare and is having a productive dialogue.

Health Access Mississippi has been developed, adopted by the Board of Trustees and you, the MSMA House of Delegates.

I am pleased to point out that the "Basic Health Plan", as introduced to the MS Legislature, is still in the legislative process and stands a good chance of passage.

The Mississippi Medical Political Action Committee and many individual members were active in the elections held last year.

Our legislative efforts, while not as successful as we would have liked, made its impact on the legislative process, and will likely pay future dividends. The Council on Legislation's recommendation to develop "mini-internship" programs in each component society is worthy of support.

The MSMA-MS Hospital Association Liaison Committee meets regularly to discuss mutual problems, and sponsored our legislative forum. For the first time we had a joint effort in visiting our Washington Congressional Delegation.

The MSMA-MS Bar Association Liaison Committee is active and in the process of updating the "Interprofessional Code".

The Council on Public Information will again be presenting awards for TV reporting, radio reporting, and newspaper reporting and to local medical society PR programs.

Our "Impaired Physician" program is still a model of effectiveness. Thank you Ellis Moffit and others.

Dr. Sidney Graves has been elevated to the position of Chairman of the Southeastern Delegation of the AMA, which means that your AMA Delegation is an even more effective voice representing you at the national level.

Our staff has prepared brochures and information and mailed them to members to be used in dealing with OSHA regulations, CLIA and RBRVS problems of implementation.

Many good things are happening as the result of efforts by our staff, Officers and the Board of Trustees. These are enumerated in your agenda package. Let me encourage you to study the issues and projects. Support them and participate in them.

Some of you will remember several years ago that I compared physicians to the Children of Israel as they were posed to enter the "Promised Land." The sent out scouts, checked out the land and then heard the committee report. "The land is good, the water fresh and sweet, the crops bountiful, but ... we are as grasshoppers in a land of giants." Pessimism pervaded, the people were discouraged, and in spite of their leadership they retreated to wander for 40 years in the wilderness until that generation died and another was raised up. Well our giants (the feds, business, the insurance industry, labor and senior citizens groups) are still out there. They see us wavering, divisive and questioning ourselves. Are we ready to retreat and wander in the wilderness is spite of the vision of our leadership just as the Children of Israel did? I think not, and I say no! We will realize our potential, we will exercise our power, our influence. The land is good, the opportunity is unlimited, and we are the people to move into that land and occupy it.

This past year I have spoken from the heart about things that I believe in strongly. I hope I have not offended anyone with my remarks, but have caused you to examine yourself and your practice. It has been a good year, one that Jo and I have enjoyed to the fullest.

I could think of no fitting way to close than the way we began last year. I would leave you with a paraphrase from the writing of Paul to the Phillipian church as my prayer for you: "Farewell, Brothers. Let your gentleness be evident to all. Whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable, if anything is excellent or praiseworthy, think about such things. If you have learned or received or hear or seen anything good in me, put it into practice. The God of Peace and love be with you." ❑

For Comments or Queries

The Editors of Journal MSMA invite you to comment on any material that appears in or is absent from the publication. If you have a query or comment, please sent it to: The Editor, Journal MSMA, PO Box 5229, Jackson, MS 39296-5229.



The President's Page

WILLIAM C. GATES, MD

"He went off and made a doctor ..."

In the May '92 "President's Page" I suggested to you that an examination of our individual and collective core might serve to give some insight to help us steer the ship of medicine through the stormy sea of change in which we now find ourselves. Apropos of the idea of looking at some of the basic fundamental building blocks of our noble profession and what makes it great, I began thinking about why we choose healing as our life's work in the first place.

I do not know how many times I heard the expression about "going off to make a doctor" when introduced or reacquainted with family and friends after being gone so long in undergraduate studies, medical school, internship and residency training. The expression was always used, I thought, with pride and sometimes I felt I could detect a note of awe - at any rate, it always made me preen ... and still does.

I cannot remember ever having the thought that I was "making a doctor" for the purpose of making a lot of money, as some of the profession's critics suggest. No, the impetus was to do whatever it took for as long as it took to garner the knowledge and skills I needed to establish my place in the healing arts. My idea of success, happiness and fulfillment was and is to achieve a fraction of the respect and admiration that I felt for my medical heroes and their caring and compassion.

My hometown role models were three in number - a father and two sons - a family practitioner, a general surgeon and a urologist. I vividly remember making house calls with "Doctor Tine" out in the backwoods of south Alabama when he was in his eighties - I did the driving and he did the diagnosing. He would sometimes fall asleep for a minute to two at the bedside, sitting in a cane-bottom straight chair while checking a pulse, palpating an abdomen or timing labor pains with his huge, hoary left hand holding his pocketwatch in his right hand. Everyone around became very still and quiet until Dr. Tine again stirred and went on with the examination. I can almost smell the faint odor of kerosene and smoke and see the dimly lit, sparsely furnished room and feel again the sense of reverence for this white-haired giant of a man, who had devoted all of his life to caring for people. He was an excellent diagnostician and the low variance between his pronouncements and the surgical findings or diagnostic studies attested to the fact. He was often consulted and his opinion highly valued when the younger physicians faced enigmatic diagnostic dilemmas. Besides being a good doctor, he was a good man and a

(Continued on page 217)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 6
JUNE 1992

Medical Ethics and Medical Technology

I recently had the opportunity to attend a seminar, the subject matter of which dealt with medical ethics as it relates to the interface between death and medical technology. A number of important issues were discussed related to the refusal or withdrawal of treatment. Patients were divided into three categories: (1) the competent adult, (2) the formerly competent adult, and (3) the patient who was never competent (for example, metal retardation). Of these categories of patients, the competent adult can make appropriate decisions as required, while the never competent patient usually has a legal surrogate who can make decisions for the patient, On the other hand, the formerly competent patient presents a dilemma for appropriate treatment unless prior arrangements have been made.

For the formerly competent patient, the most important prior arrangements (advance directives) are, in order of importance, the durable power of attorney for health care, and the living will. Whereas the living will pertains only to the withdrawal of treatment under specific circumstances, the durable power of attorney allows direction of the general medical care of the patient, including the withholding of treatment where appropriate and in the patient's best interest. Both the durable power of attorney for health care and the living will are legal entities in the State of Mississippi. In order to provide the best health care for our patients, as well as the care our patients would select if competent, we should actively encourage them to exercise both the durable power and the living will while they are still competent to do so.

George E. Abraham, II, MD
Associate Editor

Presidents's Page

(Continued from page 216)

good citizen. Thanks, Dr. 'Tine, for lighting the path and showing the way.

I suggest to you that we can change the names and places, but the story will be the same - the vast majority of the physicians have had their heroes, their dreams and their ideals that have served as the driving forces in their pursuit of careers in medicine. As Dr. Raymond Scalettar, one of our AMA trustees, has stated, "This profession, in overwhelming numbers, is composed of dedicated, dutiful, disciplined, devoted and decent human beings." I could not agree more!

Contrary to what one may hear from some quadrants, practicing medicine is more fun than it has ever been - the environment that we practice in is where the problems are. It would serve us well to keep the environment from marring the truth and beauty of the practice (we will talk about this at length at another time).

We can still recommend our profession with pride and purpose to our best and brightest in the earnest, sincere hope that they will choose to "go off and make a doctor" and that the examples we set will help them make that choice.

I hope my note finds you and yours doing well.

Best Regards,
Bill

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



To Our MSMA Friends and Colleagues:

Thank you for the resolution, such a touching gesture! You know Carl could not accept it without a speech.

A bit of our earlier years ... In 1964 upon completion of his residency there were many offers for other positions ... Cincinnati, the new Texas system, California, back to Minnesota ... all very lucrative and opportunistic positions. Jan, Mississippi born and bred, was eager to move on, to explore new horizons. I recall so well, Carl's response, "I grew up in Minnesota, it's much to cold to live; I've been Northeast and Northwest. Now I'm here, and I can grow up here as fast as I could grow up anywhere. We'll stay a while." And we did.

And he grew up ... into a world, the practice and politics of medicine, so embraced, so surrounded with support, love, concern for position, concern for each other, concern for what all of you in the House of Delegates could give to the advancement of Central Medical, MSMA, AMA and ultimately to the health care of society.

His achievements and advancements were attained only with your assistance. You elected him to offices and positions with aplomb. It was you, the delegation and his constituents, who made his career noteworthy. And Carl thanks you. He always has. I've been through several files with letters acknowledging your diligence.

We are not willing to give up this role. Carl's future now looks dismal. We are praying for complete recovery. We would settle for sightly less.

Thank you for the outpouring of concern, attentiveness, love and prayers. Every call, card, letter and visit is special. These last two months have been sheer hell for the children and me. We could not have made it without you. It's been a tough battle and we need you to continue the defense.

Thank you again. We love you all.

Jan, Karen, Julie and Gus Evers

These remarks were presented by Mrs. Carl Evers (Jan) upon her acceptance of a resolution from the MSMA House of Delegates, May 3, 1992.

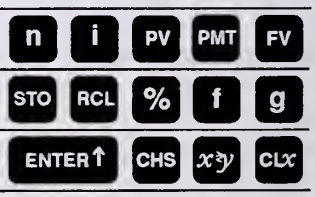
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- **No-Load Mutual Funds/Other Securities**
- **23 Years Experience**
- **Tested Asset Allocation Model**
- **Fee-Only Advisor**

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123

THE UNITED STATES ARMY RESERVE

HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

124th Annual Session Highlights



William C. Gates, MD, right.



John J. Ring, MD

Dr. Gates Installed as President; Dr. Mitchell Named President-Elect

Dr. William C. Gates of Columbus was inaugurated 1992-93 president of the MSMA at the closing meeting of the 124th Annual Session held in Jackson, April 29 - May 3, 1992.

Dr. Don Q. Mitchell of Jackson was named president-elect of the association.

The new MSMA president has served as a member of the MSMA's Board of Trustees and currently serves as a delegate to the American Medical Association. He is a fellow of the American College of Surgeons and a diplomate of the American Board of Urology. He is a member of the American Urology Association, the American Association of Clinical Urologists, and the Southern Medical Association.

Dr. Mitchell, the new president-elect, has served the MSMA in the office of secretary-treasurer for two consecutive terms. Dr. D. Stanley Hartness was elected to the office of secretary-treasurer.

Approximately 577 physicians, spouses, and guest registered for the five-day session, which featured a full program of scientific, business, and fellowship activities.

Among special guest attending the House of Delegates was Dr. John J. Ring, president of the American Medical Association. Sherry Stebel, president of the American Medical Association Auxiliary and Emily B. Shelton, president of the Southern Medical Association Medical Auxiliary both addressed the Auxiliary House of Delegates.

In addition to electing new officers, the House of Delegates took action on reports and resolutions concerning health care in Mississippi. A summary of the House actions appears on page 223 of this issue.



*Following his installation as 1992-93 President of the MSMA, **Dr. William C. Gates,** center, of Columbus is pictured with Immediate Past-President **Dr. James C. Waites,** left, of Laurel and President-Elect **Dr. Don Q. Mitchell,** right, of Jackson*



Dr. Don Q. Mitchell was elected to the office of President-elect.



Dr. D. Stanley Hartness was elected to the office of Secretary-treasurer.



Dr. Stanley Wade of Meridain collects ballot books from delegates during the Sunday session.

New Elected Officers, Board and Council Members

Delegates to the 124th Annual Session named **Don Q. Mitchell, MD** of Jackson as MSMA's 1992-93 president-elect. **D. Stanley Hartness, MD** of Kosciusko was elected to the office of Secretary-Treasurer for a three year term.

Board of Trustees - District 2
William A. Spencer, MD, Oxford
Board of Trustees - District 4
Julian C. Henderson, MD, Jackson
Board of Trustees - District 5
Dewitt G. Crawford, MD, Louisville

Delegate to AMA
Sidney O. Graves, MD, Natchez
William C. Gates, MD, Columbus
J. Elmer Nix, MD, Jackson

Alternate Delegate to AMA
W. Joseph Burnett, MD, Oxford
Alton B. Cobb, MD, Jackson
Fred L. McMillan, MD, Jackson

Editor, *Journal MSMA*
Myron W. Lockey, MD, Jackson
Associate Editor, *Journal MSMA*
George E. Abraham, II, MD, Vicksburg

Council on Budget and Finance
Charles F. Brock, MD, Greenville
Council on Constitution and Bylaws
David G. Hall, MD, Natchez

Judicial Council
District 1 - **Edwin G. Egger, MD**, Greenville
District 3 - **Nell C. Moore, MD**, Tupelo
Council on Legislation
District 1 - **John F. Lucas, III, MD**, Greenwood
District 2 - **William A. Middleton, MD**, Winona
District 3 - **R. Ray Lyle, MD**, Starkville
Council on Medical Education
District 4 - **Fred W. Rushton, Jr., MD**, Jackson
District 5 - **Stephen W. Tartt, MD**, Meridian
Council on Medical Service
District 4 - **Thomas E. Joiner, MD**, Jackson
District 5 - **Austin P. Boggan, MD**, Decatur
Council on Public Information
District 2 - **Dwalia S. South, MD**, Ripley
District 3 - **Malcolm S. Moore, MD**, Tupelo



Speaker of the House of Delegates Dr. Vann Craig *of Natchez called the 124th Annual Session to order.*



Delegates had the opportunity to meet and caucus with others from their district during the opening session of the House.



Dr. Joseph E. Johnston *of Mt. Olive served as chairman of the Reference Committee on Rules and Order of Business.*



During the Sunday Morning House Session, Delegates voted and heard reference committee reports.



Members of Reference Committee A included, left to right, ***Milam S. Cotten, MD,*** *Hattiesburg;* ***Charles A. Marascalco, MD,*** *Vicksburg;* ***John F. Lucas, III, MD,*** *Greenwood, Chairman;* ***Roy D. Duncan, MD,*** *Pascagoula; and* ***David N. Duddleston, MD,*** *Jackson.*

Action of the MSMA House of Delegates
124th Annual Session April 29 - May 3, 1992

- Urged a study of current home health care services by authorities responsible for oversight of such services with emphasis on medical necessity requirements, utilization and costs of the services.

- Directed the association to take an active role in the implementation of a Medicaid drug utilization review program and to support the MS Foundation for Medical Care in its bid to provide Medicaid drug utilization review services.

- Recommended legislation to provide sovereign immunity to physicians providing uncompensated care on a voluntary basis.

- Directed that a study be conducted to determine the feasibility of having a single Medicare fee area.

- Urged that the AMA House of Delegates adopt a policy that standards, guidelines or requirements developed by governmental or third party entities dealing with patient care demonstrate a scientifically proven positive impact on quality of care and failing this requirement such standards, guidelines or requirements be eliminated or an adequate explanation be given as to why they are perceived to be necessary by the promulgating organization.

- Commended MSMA President, Dr. James C. Waites, for his appointment to the Practicing Physicians Advisory Council to the Health Care Financing Administration.

- Directed that the AMA Delegates' Report be highlighted and publicized to the entire membership.

- Urged MSMA members to provide educational information to their patients and community organizations on the need and importance of recreational safety helmets.

- Recommended that MSMA component societies implement "mini-internship" programs and invite local legislators and other community leaders to participate in the programs.

- Adopted a $25 dues increase effective in 1993.

- Established an *ad hoc* Council of Past Presidents to develop a comprehensive plan to address health care cost and access issues.

- Directed the Board of Trustees to study the availability of new locations for annual sessions of the association beginning in 1996.

- Endorsed and commended the YWCA's operation of a Hospital Guest House in Jackson to serve the families of out-of-town patients.

- Directed the Council on Legislation to study the feasibility of seeking legislation to require the labeling of Mississippi-produced foods as "Grown in Mississippi."

- Commended the University of Mississippi School of Medicine for its activities in the field of agromedicine and urged increased efforts in this regard with the long-term goal of establishing a full program in agromedicine. ❑

Members Serving on Reference Committees of the House were:

Reference Committee on Rules and Order of Business
Joseph E. Johnston, MD, Chairman
Thomas E. Joiner, MD
Michael H. Carter, MD

Reference Committee A (Reports of Officers, Board of Trustees and Councils)
John F. Lucas, III, MD, Chairman
Milam S. Cotten, MD
David N. Duddleston, MD
Roy D. Duncan, MD
Charles A. Marascalco, MD

Reference Committee B (Reports of Officers, Board of Trustees and Councils)
David G. Hall, MD, Chairman
Mickey P. Wallace, MD
Dewitt G. Crawford, MD
Donald K. Gaddy, MD

Credentials Committee
Don Q. Mitchell, MD, Chairman
Nancy O. Tatum, MD
Stephen W. Tartt, MD

Reference Committee on Constitution and Bylaws
Chester W. Masterson, MD, Chairman
Eugene G. Woods, Jr., MD
Jack C. Evans, MD

Nominating Committee
Mal Morgan, MD, Chairman (Dist. 7)
Edwin M. Hemness, MD (Dist. 1)
Stanley Hartness, MD (Dist. 2)
John M. Patterson, MD (Dist. 3)
John J. Cook, MD (Dist. 4)
Walter D. Gunn, MD (Dist. 5)
George E. McGee, MD (Dist. 6)
William T. Avara, MD (Dist. 8)



*The MSMA Young Physicians Section and Hospital Medical Staff Section hosted as session entitled "Parameters of Care: Their Future for Medicine. **Dr. David G. Hall** of Natchez, left, served as chairman for the session. Speakers included, seated from left to right: **Dr. J. Jarrett Clinton,** Agency for Health Care Policy and Research, Department of Health and Human Services; **Dr. J. Edward Hill** of Hollandale; and **Bob H. Sebring, PhD,** Director, Division of Quality Care, American Academy of Pediatrics.*



Dr. Milam S. Cotten of Hattiesburg addressed the House reqarding the report from Reference Committee A.



Dr. Leonard H. Brandon of Starkville addressed the House of Delegates regarding a reference committee report during the Sunday Session.



Approximately 168 delegates registered and participated in the Thursday and Sunday House of Delegates sessions.

Delegates and Alternate Delegates Attending the 124th Annual Session

Amite-WilkinsonMedical Society
0

Central Medical Society
Robert L. Abney, III, Jackson
Patricia Ainsworth, Jackson
Bruce E. Atkinson, Jackson
George Ball, Jackson
Ralph Bell, Jackson
John D. Bower, Jackson
Michael Bross, Jackson
Charles Caccamise, Jr., Jackson
Guy Campbell, Jackson
Alton B. Cobb, Jackson
John J. Cook, Brandon
David N. Duddleston, Jackson
George Ellis, Jackson
Tom C. Fenter, Jackson
Howard Freeman, Jr., Jackson
Earl Fyke, Jackson
Glen Graves, Jackson
Donald Grillo, Jackson
James R. Haltom, Jackson
Karl W. Hatten, Jackson
Julian C. Henderson, Jackson
Calvin T. Hull, Jackson
Fred H. Ingram, Jackson
Michael E. Jabaley, Jackson
Ben B. Johnson, Jackson
Samuel B. Johnson, Jackson
Thomas E. Joiner, Jackson
Van Lackey, Jackson
John Paul Lee, Forest
Myron W. Lockey, Jackson
W. D. Logan, Jr., Carthage
Billy W. Long, Jackson
D. E. Magee, Jackson
Robert A. Mallette, Jackson
Michael D. Maples, Jackson
Fred L. McMillan, Jackson
Eric A. McVey, III, Jackson
Philip T. Merideth, Jackson
Jimmy D. Miller, Jackson
Don Q. Mitchell, Jackson
Ellis M. Moffitt, Jackson
John E. Moffitt, Jackson
Nina B. Moffitt, Jackson
Frank J. Morgan, Jr., Jackson
J. Elmer Nix, Jackson
Alan R. Peeples, Jackson
Max L. Pharr, Jackson
David Richardson, Jr., Jackson
Richard E. Rhoden, Jackson
Robert S. Rhodes, Jackson
Joseph H. Robinson, Jackson
Fred W. Rushton, Jr., Jackson
Robert M. Shows, Jackson
Wm. F. Sistrunk, Jackson
Larry W. Sivils, Ridgeland
D. P. Smith, Jackson
J. George Smith, Jackson
Robert Smith, Jackson
James P. Spell, Jackson
James O. Stephens, Jackson
Lou Stribling, Carthage
James E. Strong, Jr., Jackson
C. G. Sutherland, Jackson
R. Faser Triplett, Jackson
Billy L. Walker, Jackson
Mickey P. Wallace, Jackson
W. Lamar Weems, Jackson
William C. Welch, Jr., Jackson
Louis J. Wise, Jr., Jackson

Claiborne County Medical Society
0

Clarksdale & Six Counties Medical Society
George C. Furr, Clarksdale
Ed Hemness, Clarksdale

Coast Counties Medical Society
David L. Clippinger, Gulfport
Joseph Mitchell, Gulfport
Billy Wansley, Biloxi

Delta Medical Society
Michael H. Carter, Greenwood
Edwin G. Egger, Greenville
Rodney Frothingham, Greenville
Hugh A. Gamble, II, Greenville
David M. Gilder, Yazoo City
J. Edward Hill, Hollandale
John F. Lucas, III, Greenwood
Alfio Rausa, Greenwood
Travis Richardson, Drew
Walter Rose, Indianola

Desoto County Medical Society
0

East Miss. Medical Society
J. G. Alexander, Union
Robert Berg, Meridian
Austin P. Boggan, Decatur
O. Wayne Byrd, Quitman
John C. Clay, Meridian
Dewitt G. Crawford, Louisville
Wm. M. Gillespie, Jr., Meridian
Walter Gunn, Quitman
Jim Matthews, Meridian
David Richardson, Louisville
Stanely A. Wade, Jr., Meridian

Homochitto Valley Medical Society
Leslie E. England, Natchez
William Godfrey, Natchez
Sidney O. Graves, Natchez
David Hall, Natchez
James Langston, Natchez
Mal Morgan, Natchez
Alphonse M. Reed, Fayette
David R. Steckler, Natchez
Eugene Taylor, Natchez

North Central Medical Society
Arthur A. Derrick, Jr., Durant
James W. Fite, Grenada
D. Stanley Hartness, Kosciusko
Gary Holdiness, Kosciusko
William A. Middleton, Winona
George V. Smith, Grenada

Northeast Miss. Medical Society
J. T. Davis, Corinth
William L. Marcy, Tupelo
S. Jay McDuffie, Nettleton
John M. Patterson, Pontotoc
William H. Preston, Jr., Booneville
Lee H. Rogers, Tupelo

North Miss. Medical Society
W. Joseph Burnett, Oxford
William A. Spencer, Oxford
Dwalia S. South, Ripley

Prairie Medical Society
T. N. Braddock, West Point
Leonard H. Brandon, Starkville

Delegates Continued -

Michael R. Duckworth, Columbus
John T. Frazier, Columbus
Mary L. Gaines, Starkville
William C. Gates, Jr., Columbus
Thomas E. Sheffield, Columbus

Singing River Medical Society
Roy Duncan, Pascagoula
Jack Hoover, Pascagoula
Hal Moore, Pascagoula

South Miss. Medical Society
John M. Beaman, Richton
George R. Bush, Laurel
Milam S. Cotten, Hattiesburg
Dean Cromartie, Hattiesburg
Jack C. Evans, Laurel
Carolyn Gerald, Wiggins
Charles R. Jenkins, Laurel
Joe Johnston, Mt Olive
Candace Keller, Hattiesburg
Peeler Lacey, Laurel
Eric E. Lindstrom, Laurel
George E. McGee, Hattiesburg
Hilda J. McGee, Hattiesburg
David M. Owen, Hattiesburg
David Stephens, Hattiesburg
Nancy O. Tatum, Petal
James C. Waites, Laurel
Thad F. Waites, Hattiesburg
Thomas B. Whitehead, Columbia
George E. Wilkerson, Hattiesburg

South Central Medical Society
Jim Barnett, Brookhaven
Ralph L. Brock, McComb
Tom Carey, McComb
Harry C. Frye, Magnolia
P. S. Ganaraj, Tylertown
Elmo Gabbert, Meadville
William B. Larkin, Jr., Bude
Fred McDonnell, Hazlehurst
Louie Wilkins, Brookhaven

West Miss. Medical Society
George E. Abraham, Vicksburg
Robert C. Clingan, Vicksburg
Charles A. Marascalco, Vicksburg
Chester W. Masterson, Vicksburg
Wayne Pitre, Vicksburg ❑



Approximately 75 people attended the Surgery Plenary Session on New Technology: Triumph or Trivial Pursuit. The Speakers included, from left; ***Dr. C. Ron Cannon, Jackson; Dr. E. Jackson Allison, Jr., Greenville, NC; Dr. David S. Mulder, Montreal, Canada; Dr. G. Rodney Meeks, Jackson; Dr. Lon F. Alexander, Jackson, Dr. Ronald P. Krueger, Jackson and Dr. Robert S. Rhodes, Jackson, Surgery Plenary Chairman. Dr. Ruth Black,*** *Jackson was also a speaker for this session.*



Approximately 60 people attended the Medicine Plenary Session on Challenges in Geriatrics: Aiming For Our 80'. Chairman for the session was ***Dr. David N. Duddleston*** *of Jackson. Speakers for the session included:* ***Dr. Mac Addison,*** *Jackson;* ***Dr. Hector Ventura,*** *New Orleans;* ***Dr. Ken Davis,*** *Boston;* ***Dr. Michael Wise,*** *New Orleans; and* ***Dr. Brent Meador,*** *Jackson.*



Dr. David R. Steckler of Natchez was the recipient of the 1992 MSMA Community Service Award. Dr. Steckler, center, is seen with was Dr. James C Waites of Laurel who presented the award, left, and Dr. Eric McVey Vice - Speaker of the House of Delegates, right.

Dr. Mark G. Hauseman, below right, was the recipient of the 11th Annual Caldwell Memorial Award presented by the Medical Assurance Company of Mississippi. The award was presented by Dr. Ralph E. Dunn.



Russell Betcher, a senior medical student, was the recipient of the 1992 Virginia Stancil Tolbert Award.





Dr. Stanley Hartness, Chairman of the Council on Public Information, left, presented a "Certificate of Merit" to Dr. Jack Hoover, center, and Dr. Paul Moore, right, of Singing River Medical Society for their PR program recognizing high school seniors and for their societies' efforts at a local food kitchen. North Central District Medical Society also received a "Certificate of Merit" award for their community awareness program about Flu and Pneumonia Vaccines. Awards for Excellence in Medical Reporting were also presented to Geoff Pender of the Hattiesburg American, Kevin Farrell of Public Radio in Mississippi and Laurel Davison WTOK-TV in Meridian.



Thirteen Auxiliary Past-Presidents attended the Saturday morning breakfast. Others present but not show were Mrs. Kathy Carmichael of Hattiesburg current MSMA Auxiliary president, Sherry Stebel, AMA Auxiliary President and Emily B. Shelton, Southern Medical Auxiliary President.

Thanks to our 124th Annual SessionTechnical Exhibitors

Ayerst
Bedsole Medical Companies, Inc.
BFI Medical Waste System
Charter Hospital of Jackson
CIBA-Geigy Corporation
CIBA Pharmaceutical
DP Associates, Inc.
The Doctor's Company
Encyclopaedia Britannica North America
Glaxo, Inc.
Gulf South Lithotripsy
Healthcare Suppliers, Inc.
I.C. Systems, Inc.
Independent Computer Service, Inc.
Jackson Recovery Center
Key Pharmaceuticals
Medical Assurance Company of MS
Medical Pathology Laboratory, LTD
Merck, Sharp & Dohme
Miles, Inc.
MS Baptist Chemical Dependency Center
MS Foundation for Medical Care
MS Methodist Rehabilitation Center
MS Physicians Insurance Company
MS State Department of Health
MSMA Benefit Plan & Trust
OSHA Information
Parke-Davis
Pfizer Labs
Professional Disability Associates
Puckett Laboratory
River Bay Corporation
Salcris Systems
Sandoz Pharmaceuticals
Shearson Lehman Brothers
Sims Prosthetics
SmithKline Beecham Pharmaceuticals
Sta-Home Health Agency, Inc.
Summit Pharmaceuticals
Sunflower Three
Travelers Medicare
The Trusty Company, Inc
U.S. Air Force
U.S. Army Medical Department
UMC, Biochemical Genetics Lab
Weight Watchers
Wyeth-Ayerst Pediatric/Female Health Care

Medical Organization

ACOG Elects Dr. Hollis President

Richard S. Hollis, MD, a practicing obstetrician/gynecologist for more than 30 years in Amory, MS, has been elected as the future president of The American College of Obstetricians and Gynecologists (ACOG), at the group's 40th Annual Clinical Meeting in Las Vegas. He will become ACOG's 44th president and will assume that office in May 1993.

As a ACOG Fellow, Dr. Hollis has a long record of service to the College having been active at the state and national levels as an elected officer. He has served on and chaired numerous national committees including the Council of District Chairmen and the Committee on Higher Education Loan Program.

He presently serves on the Committee on Finance.

In 1987 he received the Outstanding Clinical Professor Award from his District. Because of his ongoing efforts with The Organization for Obstetric, Gynecologic, and Neonatal Nurses, ACOG's allied organization, he has been appointed as the only M.D. on their Executive Board.

During the ACOG meeting, Dr. Hollis was presented with the Outstanding District Service Award for the contributions and leadership he has provided to his District while promoting the ideals of the College.

In particular, his commitment to the education of the Fellows with the goal of improving the quality of women's health care was recognized.

At the local level, Dr. Hollis is affiliated with Gilmore Memorial Hospital where he has served as chief of ob/gyn services and has been an active member of numerous committees and presently serves on the Ob/Gyn and Surgery Committee.

He is a clinical associate professor of ob/gyn at the University of Mississippi Medical School and was one of the founders of the Physicians and Surgeons Clinic in Amory.

A member of several medical societies, Dr. Hollis has been president of the Mississippi State Ob/Gyn Society, Conrad Collins Tulane Ob/Gyn Society and the Northeast Mississippi Medical Society.

He is also a member of the Board of Trustees of Methodist Health Systems, Inc.

He received his medical degree from the Tulane School of Medicine, New Orleans. ❑

"Who Killed JKF" ... is Lectureship Topic

Over 300 attended the 14th annual lectureship sponsored by the Amite-Wilkinson Medical Society and Field Memorial Community Hospital. Dr. Paul C. Peters, professor of urology at Southwestern School of Medicine in Dallas, Texas talked about being one of the attending physicians when the late President John F. Kennedy was treated at Parkland Hospital. Dr. Peters said he learned of the assassination on his radio and went immediately to the hospital to help other doctors administering to the president. Dr. Peters said he believes Lee Harvey Oswald acted alone in the shooting.

Others speakers included Harvey Wager, III, a New Orleans attorney, who has spent years studying the assassination. Among those recognized at the meeting was Doyle Whitehead, who was chief steward on Air Force I during the Kennedy and Johnson Administration.

The Lectureship has become a major social and scientific forum for southwest Mississippi. ❑

THE DELTA REGION AIDS EDUCATION AND TRAINING CENTER grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN, Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street, Jackson, MS 39216-4505



MSMA President James C. Waites, left, and Mrs. Syliva Walker, right, MSMA Auxiliary President, presented Mrs. Tish Hughes, Health Projects Chairman of the Junior League of Jackson, a framed copy of the MSMA Resolution recognizing the League for their fund raising efforts on behalf of the UMC Children's Cancer Clinic. The award presentation was made on the first anniversary of the opening of the new cancer clinic.



At right, Junior League members regularly serve as volunteers in the UMC Cancer Clinic.



Amite-Wilkinson Medical Society and Field Memorial Community Hospital Lectureship. *Pictured from left to right are Dr. Richard Field, Jr., of Field Hospital; Attorney Harvey Wagner of New Orleans, Dr. Paul Peters of Dallas, and Dr. Richard Field, III, of the Field Hospital.*

What employers — like doctors — are asking Employer Plus.

Q. ***Should an employer provide benefits for employees, or just give them a raise in pay and let them fend for themselves?***

A. *If a pay raise is given, it will cost you as the employer additional dollars by increasing the employer matching social security taxes and increasing worker's compensation premiums. However, if you provide them with employer paid benefits, you will not incur these additional costs.*

Q. ***Will my employees settle for benefits rather than pay increases?***

A. *A study done by the Harvard Business School during the late 80's found that employees rated increased benefits as the next best thing to a raise in pay.*

How Employer Plus can help!

Good benefits help to retain good employees. And, if you split the cost of the benefits with the employees, both of you will come out ahead.

Here's why.

Employer Plus offer our clients an IRS Qualified "Section 125 Cafeteria Plan" for their employees' benefits plan. This plan allows each employer to withhold a portion of its employees' salary to be used to pay for insurance premiums, medical expenses, dependent care, and savings for retirement. The amount that each employee sets aside from their salary to pay for these benefits is tax exempt from FICA Withholdings, Federal Income Tax Withholdings and State Income Tax Withholdings.

In doing this, a bigger take-home amount is produced for your employees, even though you the employer have not actually given them a raise. The increase simply comes from the amount that employees' were paying the government in tax dollars.

Here is just a sample of the benefits that Employer Plus offers our clients in our Cafeteria Plan. All of these benefits are with top-of-the-line, national companies:

- **Health Insurance**
- **Dental Insurance**
- **Vision Insurance**
- **Disability Income Insurance**
- **Life Insurance**
- **Dependent Care**
- **Medical Reimbursement**
- **Retirement Plans**
- ***... and more***

Employer Plus has saved the best part for last...

Our Cafeteria plan will lower your labor cost. For every dollar that your employees run through the Cafeteria Plan — you the employer — will save 7.65%, because you will not have to pay the employer matching share of social security tax. Also, worker's compensation premiums are not calculated on benefit bonuses.

If you are interested in giving more to your employees — and taking home more money from your practice — give us a call.

We have many ways we can save you money!



Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.

New Members

Chris J. Campbell, Oxford. Born Turoma, WA, March 22, 1959; MD Pennsylvania State University, College of Medicine, Hershey, PA 1985; interned one year Allentown Affiliated Hospitals, Allentown, PA; anesthesiology residency University of Florida College of Medicine, Gainesville, FL 1986-89; elected by North Mississippi Medical Society.

John J. Durfey, Jackson. Born Canton, MS, September 28, 1962; MD University of Mississippi School of Medicine, Jackson, MS 1988; interned one year, University of Texas Medical Branch, Galveston, TX; anesthesiology residency, same, 1989-92; elected by Central Medical Society.

Jonathan D. Fratkin, Jackson. Born Brooklyn, NY, September 22, 1944; MD State University of New York at Buffalo School of Medicine, Buffalo, NY 1970; interned and anatomic pathology 1970-72, Ophthalmology, same 1974-77, and neuropathology, same, 1978-82; elected by Central Medical Society.

John P. Fullenwider, Oxford. Born Magnolia, AK, July 27, 1954; MD University of Arkansas for Medical Sciences, Little Rock, AK 1984; pathology internship, same, 1984-85; pathology residency, Baptist Memorial Hospital, Memphis, TN 1985-88; elected by North Mississippi Medical Society.

William B. Geissler, Jackson. Born Omaha, NB, April 8, 1959; MD Tulane University School of Medicine, New Orleans, LA 1985; interned and orthopaedic surgery residency, University Medical Center, Jackson, MS 1985-87 & 1989-90; fellowship, orthopaedic trauma, Aarau Switzerland 1988; fellowship Aathroscope/Sports Medicine, Richmond, VA 1990-91; elected by Central Medical Society.

Norris R. Jagnandan, Columbus. Born South America August 23, 1950; MD University of Mississippi School of Medicine, Jackson, MS 1980; interned one year, Army Medical Center, Honolulu, Hawaii; elected by Prairie Medical Society.



Helen L. Lucia, Jackson. Born Brooklyn, NY, October 23, 1942; MD New York University School of Medicine, New York, NY, 1968; interned one year Ben Taub Hospital, Houston, TX; pathology residency Peter Bent Brigham Hospital, Boston, MA, 1969-74; elected by Central Medical Society.

John E. Mann, Jr., Meridian. Born Greenwood, MS, July 6, 1939; MD University of Mississippi School of Medicine, Jackson, MS 1966; interned one year, Miss Baptist Medical Center, Jackson, MS; elected by East Miss Medical Society.

Carroll M. McLeod, Jackson. Born Hattiesburg, MS, December 2, 1962; MD University of Mississippi School of Medicine, Jackson, MS 1988; interned one year Ochsner Foundation Hospital, New Orleans, LA; anesthesiology residency, University of Texas Medical Branch, Galveston, TX 1989-92; elected by Central Medical Society.

William S. Renaudin, Clarksdale. Born New Orleans, LA, August 4, 1935; MD Tulane University School of Medicine, New Orleans, LA 1960; interned one year Southern Baptist Hospital, New Orleans, LA; ob-gyn residency, Charity Hospital, New Orleans, LA, 1961-66; elected Clarksdale & Six Counties Medical Society.

Philip A. Schaeffer, Biloxi. Born Gainesville, TX, May 24, 1935; MD Louisiana State University School of Medicine, New Orleans, LA, 1960; interned one year, Greensboro, NC; psychiatry residency, Charity Hospital, New Orleans, LA 1963-66; elected by Coast Counties Medical Society.

John M. Searles, Jr., Jackson. Born Minneapolis, MN, September 14, 1949; MD University of Colorado School of Medicine, Denver, CO, 1981; general surgery residency, Emory University, Atlanta, GA, 1981-86; fellowship, head & neck 1986-87; plastic surgery residency, Eastern Virginia Medical School, Norfolk, VA, 1988-91; elected by Central Medical Society.

Charles L. Secrest, Jackson. Born Ft. Worth, TX, June 14,1959; MD University of Mississippi School of Medicine, Jackson, MS, 1986; interned and general surgery, Baylor University Medical Center, Dallas, TX 1986-88; urology residency, University Medical Center, Jackson, MS 1988-91; elected by Central Medical Society.



CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

New Members/continued

Douglas N. Smith, Meridian. Born Kirksville, MO, February 26, 1949; DO Kirksville College of Osteopathic Medicine, Kirksville, MO 1978; interned one year Sun Coast Hospital, Largo, FL; elected by East Miss Medical Society.

Dawn M. Sumrall, McComb. Born New Orleans, LA, May 11, 1962; MD University of Texas Medical School, Houston, TX 1988; ob-gyn residency, University Medical Center, Jackson, MS 1988-92; elected by South Central Medical Society.

Clara A. Thiel, Jackson. Born Jackson, MS, February 9, 1961; MD University of Mississippi School of Medicine, Jackson, MS 1988; interned and neurology residency, University Medical Center, Jackson, MS 1988-92; elected by Central Medical Society.

Stephen T. Threadgill, Oxford. Born Greenville, MS, May 7, 1961; MD University of Mississippi School of Medicine, Jackson, MS 1987; interned and internal medicine residency University of Kentucky Medical Center, Lexington, KY, 1987-90; gastroenterology residency, Medical College of Georgia, Augusta, GA, 1990-92; elected by North Mississippi Medical Society.

Thomas E. Weed, Natchez. Born New Orleans, LA, March 2, 1951; MD Tulane University School of Medicine, New Orleans, LA 1977; interned and surgery residency, Ochsner Foundation Hospital, New Orleans, LA, 1977-82; thoracic surgery residency, Baylor University Medical Center, Houston, TX, 1982-83; elected by Homochitto Valley Medical Society.

Gregg A. Willis, Tupelo. Born Lee County, June 14, 1960; MD University of Mississippi School of Medicine, Jackson, MS 1988; interned and ob-gyn residency, University of Tennessee, Chattanooga, TN, 1988-92; elected by Northeast Mississippi Medical Society. ❑

Deaths

W. Richard Campbell, Columbia. Born Columbia, MS, June 28, 1927; MD University of Tennessee College of Medicine, Memphis, TN 1954; interned John Gaston Hospital, Memphis, TN, one year; one year general practice residency, Huey P. Long Charity Hospital, Pineville, LA; died April 14, 1992, age 64.

Garrison, Harvey F, Jackson. Born Seminary, MS Oct. 18, 1905; MD University of Tennessee College of Medicine, Memphis, TN 1929; interned one year John Gaston Hospital, Memphis, TN; pediatric residency Children's Memorial Hospital, Chicago, IL, one year; died March 11, 1992, age 86.

Lawrence W. Mahalak, Jr, Jackson. Born Alexandria, LA, January 12, 1945; MD University of Mississippi School of Medicine, Jackson, MS, 1969; interned one year U.S. Naval Hospital, Portsmouth, VA; neurology residency, University Medical Center, Jackson, MS 1973-76; died April 12, 1992, age 47.

Charles H. Martin, Natchez. Born Kokomo, MS, May 5, 1931; MD University of Mississippi School of Medicine, Jackson, MS, 1957; interned and medicine residency, University Medical Center, Jackson, MS 1957-58 and 62-65; died April 21, 1992, age 60. ❑

ADVANCES IN THE
WAR ON PAIN

The multi-disciplinary treatment team at the Rehabilitation Institute of New Orleans recognizes pain as a manageable condition compromising an individual's quality of life. We understand the difficulty of identifying physical sources of chronic pain.

The following services are offered for physical, psychosocial and vocational rehabilitation:

- Comprehensive Evaluations
- Work Capacity Evaluation
- Work Recovery
- Physical Therapy
- Occupational Therapy
- Nursing
- Recreational Therapy
- Psychology
- Bio Feedback
- Stress Management

RINO

REHABILITATION INSTITUTE OF NEW ORLEANS
AT F. EDWARD HEBERT HOSPITAL

TELEPHONE:
(504) 363-2200
TOLL-FREE:
1-800-426-3085

One Sanctuary Drive • New Orleans, Louisiana 70114

REHAB DIVISION OF NME

Meetings

NATIONAL AND REGIONAL

American Medical Association, Annual Meeting, June 21-25, 1992 Chicago; Interim, December 6-9, Nashville, TN. James S. Todd, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

STATE AND LOCAL

Mississippi State Medical Association, 125th Annual Session, April 28-May 2, 1993, Biloxi, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Mississippi Academy of Family Physicians, Annual Meeting, August 5-8, 1992, Gulf Shores, AL. Leontine Stevens, Executive Secretary, PO Box 1215 Ridgeland 39158.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, MD, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: Ms. Jenkins, PO Box 4053, West Station, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, David G. Hall, MD, Secy., 150 Jeff Davis Blvd, Suite 130, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, P. Morris Parsons, MD, PO Box 590, Ackerman 39735. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Tuesday, March, June, September, November, December. Tom E. Stanford, Jr., MD, Secy., PO Box 7240, Tupelo 38802. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Catherine E. Gleason, MD, Secy., 1306 Belk Blvd., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, Mary S. Gaines, MD, Secy., 401 Hospital Rd., Starkville, MS 39759. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Hal Moore, MD, Secy., 1214 Famsworth Avenue, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Chester Masterson, MD, Secy., 1901 Mission 66, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials of the Accrediation Council for Continuing Medical Education (ACCME)" and the Council on Medical Education of the MSMA. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39202-1166

North Mississippi Medical Center
830 Gloster Street
Tupelo, MS 38801

Forrest General Hospital
Mamie Street and Highway 49 South
Hattiesburg, MS 39401

Mississippi Baptist Medical Center
1225 N. State Street
Jackson, MS 39202

Gulf Coast Community Hospital
180 DeBuys Rd.
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Seargeant Prentiss Drive
Natchez, MS 39120

King's Daugthers Hospital
Highway 51 North
Brookhaven, MS 39601

Charter Hospital of Jackson
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
150 Reynoir St.
Biloxi, MS 39533

Jeff Anderson Regional Medical Center
2124 14th St.
Meridian, MS 39301

Park View Regional Medical Center
100 McAuley Dr.
Vicksburg, MS 39180

Methodist Medical Center
1850 Chadwick Dr.
Jackson, MS 39204

Golden Triangle Regional Medical Center
2520 Fifth St., North
Columbus, MS 39701

Northwest Mississippi Regional Medical Center
Hospital Dr.
Clarksdale, MS 38614

Singing River Hospital
2809 Denny Ave.
Pascagoula, MS 39567

Greenwood Leflore Hospital
1401 River Rd.
Greenwood, MS 38930

Memorial Hospital at Gulfport
4500 13th St.
Gulfport, MS 39501

Baptist Memorial Hospital of North Mississippi
Highway 7, South
Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital
969 Lakeland Dr.
Jackson, MS 39216

Delta Regional Medical Center
1400 E. Union
Greenville, MS 39704

Methodist Hospital
5001 W. Hardy St.
Hattiesburg, MS 39401

MS State Department of Health
PO Box 1700
Jackson, MS 39215-1700



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

A Risk Retention Group

Personals

Paul M. Allen, a Gynecologist and Obstetrician practicing in Pascagoula gave a presentation on *Polymerase Chain Reaction and Morphologic Studies on Inflammatory Lesions of the Proximal Urethral Mucosa in Patients with Urethral Syndrome: Preliminary Data for a Multicenter Study Group* at the 1992 Biennial Meeting of the American Society for Colposcopy and Cervical pathology in Orlando, FL during March.

Gene R. Barrett of Mississippi Sports Medicine and Orthopaedic Center, Jackson, attended the Arthroscopy Association of North American meeting in Boston Massachusetts. He also presented *Who Hurt Their Knee in 1991 and Why* at St. Dominic Hospital's Monthly Conference.

C. Ron Cannon of Jackson attended the American Academy of Otolaryngology-Head & Neck Surgery Home Study Course meeting in Palm Desert, California in April.

Samuel J. Creekmore of New Albany has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Ralph C. Daniel, III, of Jackson was visiting professor at University of Alabama at Birmingham's Department of Dermatology.

Maurice James of Jackson lectured on *Retinal Branch Vein Occlusions, Medical Management and Surgical Therapy* at a Retinal and Vitreal Disorders Conference held at Vanderbilt University Medical Center in Nashville, TN.

Robert Jordan of Meridian announces the relocation of his medical practice to Rush Family Medical Center, 840 Hwy 19 North, Meridian.

William F. Krooss, II, of Jackson has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Frank J. Morgan of Jackson was recently elected as President of the Examination Board for the Federation of State Medical Boards, Inc. for the term 1992-1993.

Francis S. Morrison, of Jackson attended the annual meeting of the American Society for Apheresis in Chicago where he chaired a session and presented two papers. The papers were concerned with the use of *Erythrocytapheresis* and *Toxicity Associated with the Staph A Column* He concluded his year as president of the society and was appointed to the chairmanship of the International Affairs Committee.

Don Rudeen of Picayune was honored recently by St. Michael's farm for boys. Dr. Rudeen has been St. Michael's family doctor since its founding in 1954.

Lamar Thaggard recently received the first Distinguished Service Award presented by the Carthage Chamber of Commerce.



Laramie C. Triplett of Jackson announces the relocation of his practice to West Jackson Family Medical Center, Department of Family Medicine, UMC, 1920 Chadwick Drive, Jackson.

James C. Waites of Laurel has been appointed to a new physicians' advisory council by Health and Human Service Secretary Louis Sullivan.

Murray Whitaker, a cardiologist practicing in Vicksburg, was inducted as a fellow of the American College of Cardiology. ❑

Physicians' Recognition Award

Six MSMA members were named recipients of the AMA Physicians' Recognition Award in April 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These six individuals are presented below by medical society.

Central Medical Society
Raymond F. Grenfell, MD
David D. Richardson, MD

Claiborne County Medical Society
Gloria Jean Butler, MD

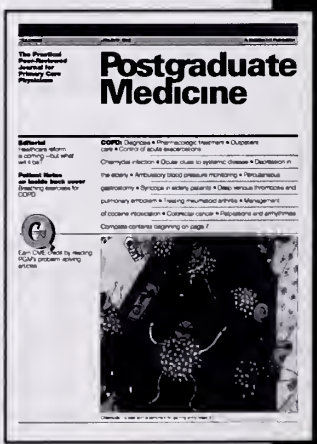
Coast Counties Medical Society
William L. Bass, MD
Eldon Duane McClain, MD

West Mississippi Medical Society
John B. Ederington, MD

US THEM







WHEN YOU NEED TIME ON YOUR SIDE, THE CHOICE IS CLEAR.

NO CLINICAL CLUTTER– PGM ARTICLES ARE CLEAR, CONCISE, WELL ILLUSTRATED, AND PRACTICAL.

Postgraduate Medicine

MSMA-SPONSORED
Standard Insurance Claims Forms
HCFA 1500

☐ • **Old two-part snap-out, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part snap-out, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$37.25 Plus State Sales Tax**	**$45.00 Plus State Sales Tax**

☐ • **Old two-part continuous, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part continuous, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$39.00 Plus State Sales Tax**	**$47.00 Plus State Sales Tax**

- **All orders plus 6% Mississippi Sales Tax unless your organization is tax exempt**
- **Price includes all delivery and handling costs**
- **Rapid Shipment via UPS**

ORDER INFORMATION

RETURN ORDER BLANK TO:

Order Department - Insurance Forms
Mississippi State Medical Association
PO Box 5229
Jackson, MS 39296-5229

Call in orders:

(Toll Free In-State Wats)	1-800-898-0251
Jackson and surrounding area	354-5433
MSMA Fax Number	352-4834

SHIP ORDER TO:

_____
_____
_____
_____
(Please indicate street address and zip code)

_____
(name of individual placing order)

_____
(purchase order #)

_____
(phone #)

AMA Confronts Epidemic of Family Violence



More than 2 million cases of child abuse and neglect are reported each year. Each year, as much as 3% of the elderly population is abused. According to a recent article in the *Journal of the American Medical Association*, domestic violence is the single largest cause of injury to women in the U.S.: more common than car accidents, muggings and rape combined. Other forms of family violence, including sexual abuse and mistreatment of the elderly, have barely been addressed.

Conservative estimates put the annual medical costs of family violence at $44 million — the equivalent of almost 100,000 days of hospitalizations; almost 30,000 emergency department visits; and almost 40,000 visits to a physician each year. Virtually all estimates indicate that the problem continues to grow.

The AMA has declared a new initiative against family violence by launching its national Campaign Against Family Violence to provide physicians with specific, practical education on the diagnosis of violence-related problems, and the counseling and treatment of these victims.

Physicians are the key to ending the cycle of violence. They are the people in a position to identify victims and potential victims of abuse, to make sure victims receive treatment, and most important, make sure the violence is not repeated.

Robert E. McAfee, MD, the AMA's associate vice chairman, said 570,000 physicians will receive letters from the AMA urging them to join the Physicians' Campaign Against Family Violence. "We want an expression of support for the program from every physician regardless of specialty," he said. The campaign will show us how to learn from each other, to start programs in our communities and to lobby for state legislation to finance agencies which will support our efforts. Responses will impact the AMA's guidelines on family violence due to be released in January, 1992.

AMA guidelines, developed for primary care physicians, will help physicians recognize abuse from a list of warning signs, question patients in a caring way and refer them to social service agencies or shelters for legal aid or counseling support.

With the help of the AMA Auxiliary, the AMA plans to develop comprehensive directories of local agencies to which physicians can refer these victims.

Currently, abuse victims can get help through the 24-hour National Domestic Violence Hotline at 1-800-333-7233, or by writing the Council on Battered Women, P.O. Box 54383, Atlanta, GA 30308.

The AMA, involved in this issue since 1982, has gone beyond recommending national policy. Recent activities include national conferences on child abuse and neglect, and on the prevention of family violence. AMA research and reports examine child, sexual and elder abuse, missing and exploited children and child pornography. Upcoming anti-violence AMA projects include:

- the AMA national family violence prevention resource center assembling research and resources for health care providers,
- surveying of physicians and public attitudes and knowledge about family violence to establish a baseline against which to measure the success of AMA anti-violence efforts,
- promoting research on violence as a public health problem, and
- influencing public policy regarding violence treatment and prevention.

AMA member Kevin Fullin, MD, of Kenosha, Wisconsin, featured in our national promotions and who established the first Domestic Violence Advocate Program in his state, says: "Being a patient advocate is what being a physician is all about."

Placement Service
Physicians Wanted

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

TIRED OF WORKING FOR SOMEONE ELSE WITH NO CHANCE FOR OWNERSHIP?

Mississippi. Excellent opportunities for career-oriented Emergency Physicians. OWNERSHIP OPPORTUNITIES. Local physician-owned and managed group with contracts in North, Central, and Southcentral Mississippi with potential income of $200,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Positions available now. Please send your CV to P.O. Box 13849, Jackson, MS 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

PF, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

Greater Meridian Health Clinic is seeking a Medical Director. The Director will manage an experienced and enthusiastic management team in the area of primary care delivery. Responsibilities include: provider supervision and scheduling, planning, implementation and evaluation of medical services, and oversight of quality assurance programs. Candidates should be Mississippi licensed (licensure eligible), board eligible/certified in Pediatrics, Internal Medicine or Family Practice and should expect to maintain a part-time medical practice at the center. Nice facility, excellent benefits, malpractice paid, paid retirement, good salary. CV's of inquiries should be directed to: Wilbert L. Jones, Executive Director, 2700 6th Street, Meridian, MS 39301 (601) 693-0151 FAX (601) 693-9182.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.



Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

Family Practice/ ER Physician needed on a regular weekday basis (15 to 20 hours a week) and to work alternate Saturday's. North East Jackson. Call 957-2273.

Excellent Opportunity for Board-Certified or Board Prepared Emergency Physician with interest in teaching residents to join stable, all Board-Certified group. Recently approved Emergency Medicine Residency. Community emergency department with 36,000 visits per year. Excellent first year compensation as independent contractor with early partnership potential. Flexible scheduling with extended double coverage. **Reply to Sarah B. d'Autremont, M.D., FACEP or Marie Wegeman, Baton Rouge General Medical Center, P.O. Box 2511, Baton Rouge, La., 70821. (504) 387-7053.**

SOUTHEAST; GENERAL SURGERY-Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice w/ coverage from surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician $150,000 net before taxes for 2 years. Richard Glehan 800-221-4762.

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

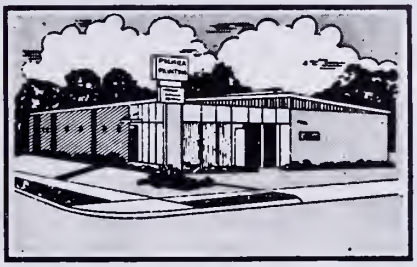
We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

TIRED OF NIGHT CALL AND ADMINISTRATIVE BURDENS?

Mississippi. An incredible practice is now available within a progressive, established group of Family and Industrial Medicine Physicians. No hospital call. OWNERSHIP OPPORTUNITIES in this expanding Episodic Care and Industrial Medicine Clinic system. Potential income of $150,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Have a busy practice from day one, with extremely high, long-term income potential. Please send you CV to P.O. Box 13849, Jackson, Mississippi 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

MONTANA CLINIC - seeking a Family Practice/GP physician for a unique primary care practice. Outstanding hospital and community support. Guaranteed income and excellent benefit package. Every type of outdoor recreation available at your back door. No crime, drug, or traffic problems in this community. A wonderful place for your family! Call or send CV to FHS, 4656 So. Utah Ave. Butte, MT. 59701. phone: 406-494-1448.

LIBRARY
JUN 29 1992
N.Y. Academy of Medicine

Classified

Ames Clinistat Dry Chemistry Analyzer purchased new in January, 1991, wanting to sell for $8900. Call Dr. Chuck Borum, 150 Jefferson Davis Boulevard, Natchez, MS 39120, phone 442-0200.

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captian Mike McRaney, (601) 875-9462, PO Box 999, Biloxi, MS.**

For Sale: NEC 310 Computer System, two - 310 66 MB Fixed Disk, one - Diskette Drive, four - Display Stations with Keyboards (work stations), one - Modem 201 (For electronic transmissions), complete medical software with full support available adequate for a three physician practice $5,000.00 -- The Segars Clinic, PA, Iuka, MS, Telephone # (601) 423-1000 - Ask for Mary.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

Items for the Placement Service or Classified Section should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

Index to Advertisers

Avanti 4

CancerPay Plus 6

Deposit Guaranty Investments 8
Disability Determination 241
Doctors Insurance Reciprocal 236

Eli Lilly & Co. 7
Employer Plus, Inc. 231

Harreld Chevrolet-Oldsmobile 232

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 218
MS Emergency Association 242
MS Methodist Rehabilitation Center.. **second cover**
MS Physicians Insurance Company 212
MSMA Benefit Plan & Trust ..... **fourth cover**

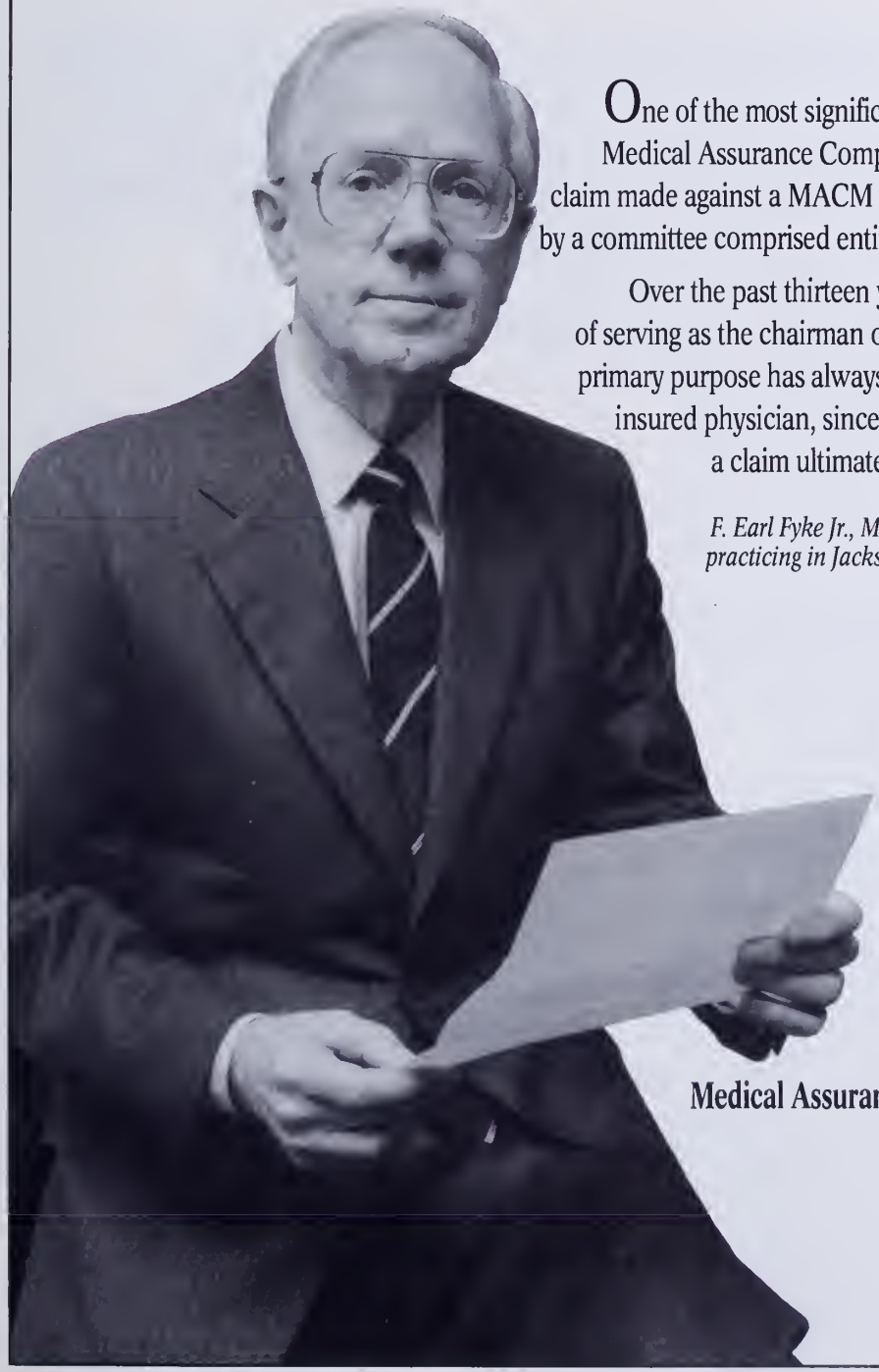
Parke-Davis ..... **insert**
Post Graduate Medicine 238
Premier Printing 243

Rehabilitation Institute of New Orleans 234

The Doctors' Company 208
Trustmark 237

US Air Force 233
US Air Force Reserve 242
US Army Active 207
US Army Reserve 219

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

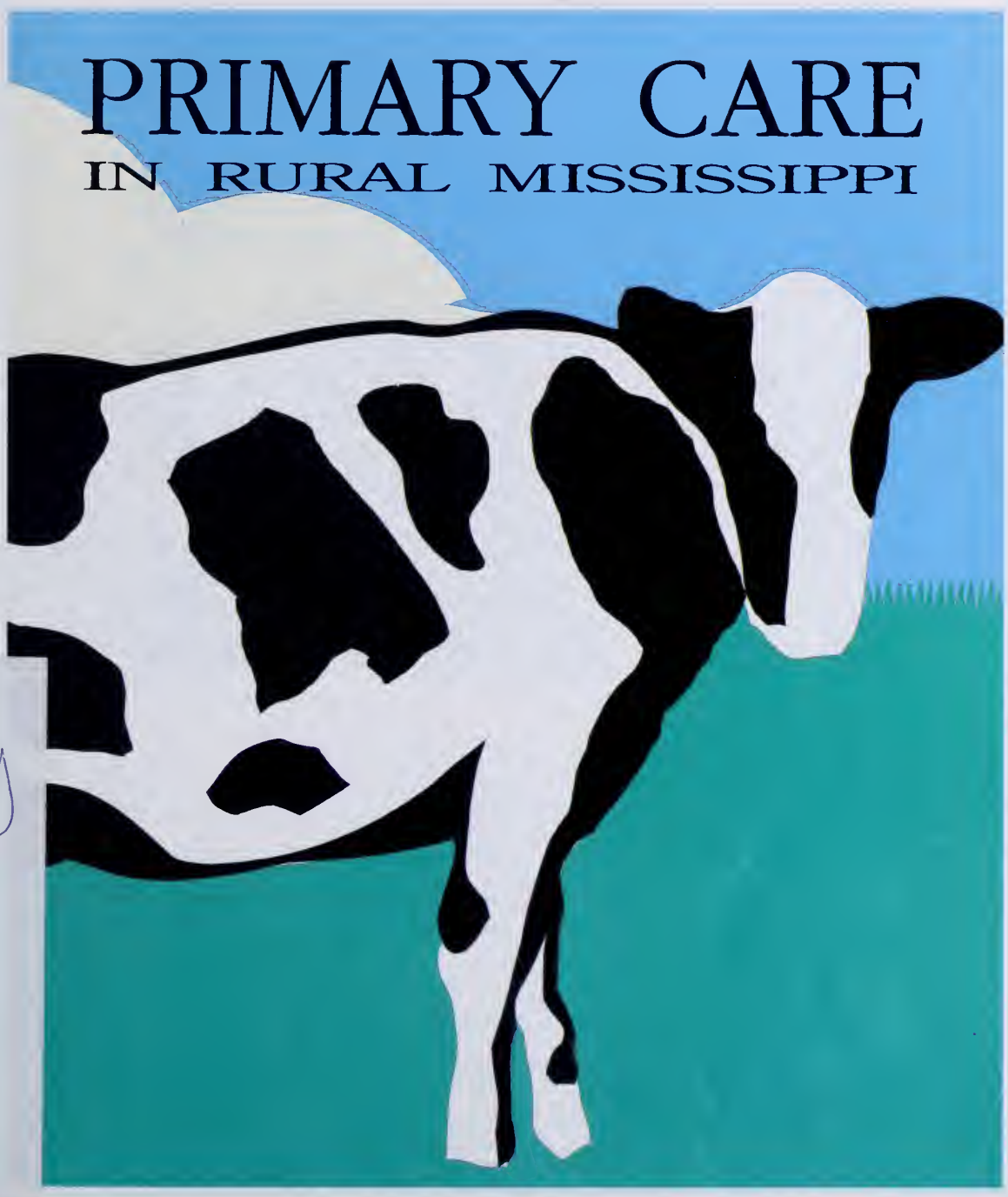
MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JULY 1992

PRIMARY CARE IN RURAL MISSISSIPPI



N.Y. ACADEMY OF MED
2E E 103RD ST
NEW YORK NY 10029-5207

Library



"And I thought rehab was just a fancy name for therapy."



Dr. Karl Hatten doesn't work in rehabilitation, but he knows more about it than many so-called experts. He got his experience first-hand. As a nephrologist, he's spent more than 25 years helping patients deal with life-threatening diseases. But when he was hit by a stroke, he saw his own life hanging by a thread.

"Like many doctors, I had been confused by all the physical therapy programs that refer to themselves as rehab," he says. "My experience at MMRC taught me there's a big difference.

"The staff was incredibly supportive. They set realistic goals for my recovery, and helped me regain my self-confidence." In six months as a patient Dr. Hatten learned more about rehab than in 25 years as a doctor. Now he understands why MMRC is the South's leading rehabilitation center.

Today, he's back at work. With a fresh outlook on life. And a new perspective on rehabilitation.

Because when it's done right, rehab can do a lot more than repair a patient's body. It can even help a doctor see things more clearly.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JULY 1992 VOLUME XXXIII NUMBER 7

SCIENTIFIC ARTICLES

Accessibility to Primary Care In Mississippi 245
Mark Ladner, MD, Gregory H. Blake, MD, MPH
William Replogle, PhD

Laparoscopy For The Management of Appendicitis 249
V. John Bagnato, MD

SPECIAL ARTICLE

Mississippi Comprehensive Health Insurance Risk Pool 253

EDITORIALS

"Pondering Professionalism - Profit and Piracy or Priesthood and Philanthropy?" 256
William C. Gates, MD

DEPARTMENTS

Letters 257
Current Opinons 259
Medical Organization 260
From the Univeristy of Mississippi Medical Center 261
Personals 265
Placement Service 271

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD,
Chairman
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
William C. Gates, MD
President
Don Q. Mitchell, MD
President-Elect
D. Stanley Hartness, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔	1. Structured for Physician's offices	Savings Up To 15 %
✔	2. Established by Your Association	
✔	3. Savings over what you currently are paying	
✔	4. Responsive to your needs	
✔	5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 7

July 1992

Dear Doctor:

Are you a new chief of staff, medical staff committee chairperson, clinical department head or other medical staff? Do you need the skills of an arbitrator, facilitator, manager, negotiator, problemsolver and peacemaker? Here's where to gain them.

INTERACTIONS: MEDICAL STAFF LEADERSHIP PROGRAM,
October 2-3, 1992, Downtown Chicago Marriott, Chicago, Illinois.

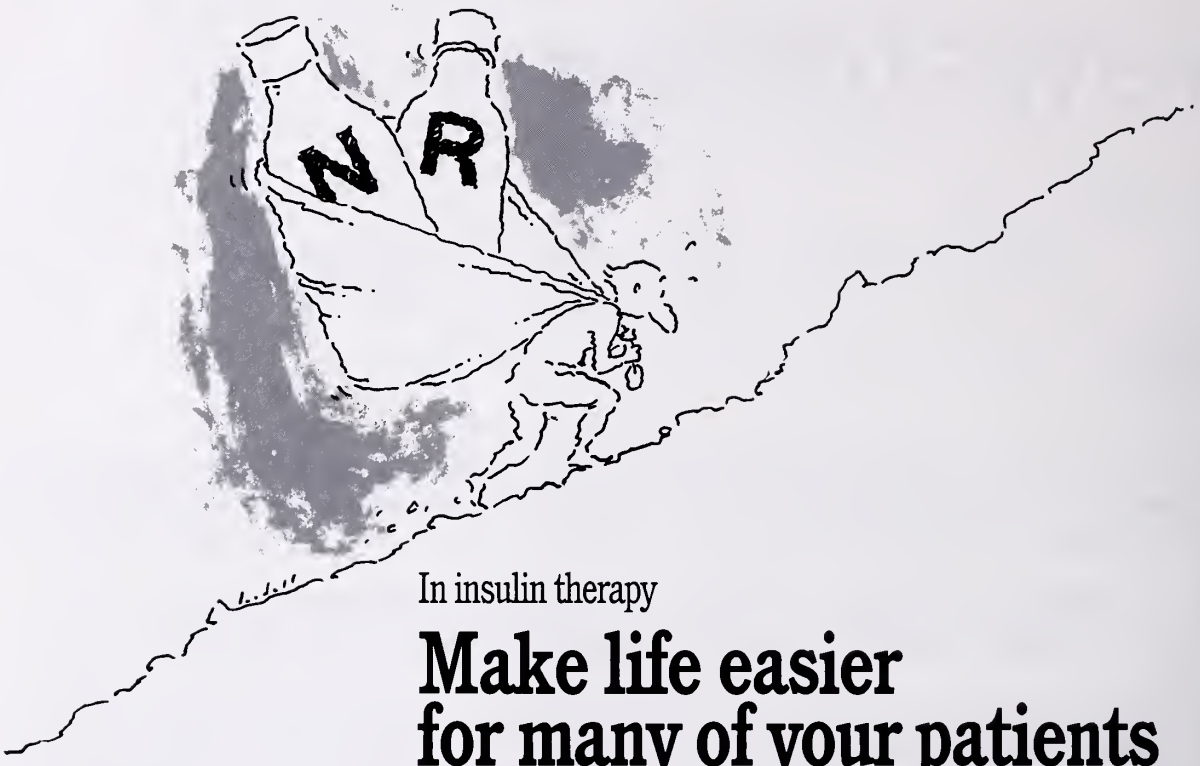
During this two-day program, you'll enhance the skills you need to successfully merge your clinical role with your medical staff leadership responsibilities. An essential resource for new medical staff leaders, this program covers critical areas: credentialing, medical staff bylaws development, outcomes, management, negotiation, group communications, conflict resolution, meeting effectiveness, parliamentary procedure and peer review.

Cost for members of the American Medical Association is $495 and $595 for nonmembers. You can receive a $100 early-bird discount by registering before August 1. Discounts are also available for groups of three or more registrants from the same medical staff. For immediate registration or information, call 1-800-621-8335.

MARK YOUR CALENDAR !!

The MSMA 125th Annual Session will be held
April 28 - May 2, 1993
at the Royal d'Iberville Hotel, Biloxi, Mississippi

The University of Washington School of Medicine has made available the videotape version of *Arthrocentesis & Injection Techniques For the Primary Care Physician*, a national conference presented by leading physicians in the field. This home study course is approved for 2.5 CME Category 1 credits of the Physician Recognition Award of the American Medical Association. The Video program provides didactic material followed by hands-on training in joint aspiration and injection as well as injection of selected bursae, tendon sheath and other soft tissue. All lectures, slides, questions and answer periods and demo/practice sessions for the entire meeting are included. Cost of the course is $125, plus $13 shipping and handling. CME credit is obtained after successful completion of a self examination which accompanies the course. For more information about course content or to place an order, call 1-800-284-8433 or 1-609-427-0838.



In insulin therapy

Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer. No more mixing. No more mixing errors. All of which makes living with diabetes a little easier for patients. And compliance a lot easier to achieve.



Humulin® 70/30

70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

The patient-friendly premix

Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

HI-7905-8-249327 ©1992, ELI LILLY AND COMPANY

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 7

Immunization Rate Reflects Commitment

Jackson - Mississippi, last in the nation is so many things, is a role model in childhood immunization. Mississippi's immunization rate of 73.8 percent of 2-year-olds is among the best in the nation, according to State Epidemiologist Dr. Ed Thompson. In many states, the rate is 50 percent or less.

In the Meridian area 96 percent of the children younger than 2 are immunized against childhood disease. The Delta ranks second to the Meridian area and also beats the national immunization average, with 83 percent of its children under 2. Even with this good record, more than 26 percent of Mississippi's children are not being immunized against contagious diseases.

Mississippi is participating in the Carter-Bumpers Campaign for Early Immunization: Every Child by Two. The Campaign hopes for a 90 percent immunization rate for children by age 2 by the year 2000.

Tobacco Prevention Award

Jackson - Eight southeastern states earned the 1992 Regional Coalition Award from the Association of State and Territorial Directors of Public Health Education (ASTDPHE). The award was given for "significant attainment toward tobacco prevention and control in the region."

The Mississippi State Department of Health's Director of Health Promotion and Education Ellen Jones accepted the award on behalf of the Region IV Tobacco Contacts and Mississippi's work as lead agency in organizing tobacco prevention efforts. The award was given at the ASTEDPHE annual meeting in May in Kansas City, Missouri. The other Region IV states are Alabama, Florida, Georgia, Kentucky, North Carolina, South Carolina, and Tennessee.

The MSDH Office of Health Promotion and Education began organizing the states in tobacco prevention activities in 1990. Ms. Jones and Cheryl Grubbs, tobacco prevention coordinator, started a quarterly newsletter that includes tobacco prevention information and activities from participating states.

They also worked to earn an $8,000 Association of State and Territorial Health Officials (ASTHO) mini-grant for tobacco use prevention. The mini-grant will be used for planning and organization of a regional effort that will build capacity and increase training in tobacco use prevention and control. Mississippi is one of eight states awarded money through the grant. Other related activities include actively promoting tobacco-related legislation and sharing technical information as they relate to each state's activities.

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

Accessibility To Primary Care In Mississippi

MARK LADNER, MD
GREGORY H. BLAKE, MD, MPH
WILLIAM REPLOGLE, PhD

The factors affecting accessibility to primary care in Mississippi extend beyond the overall ratios of primary care physicians to the population. The geographic distribution of physicians between rural and urban areas and a patient's ability to pay for medical care are also factors.[1,2]

The Journal of Mississippi State Medical Association has addressed access to primary care in terms of physician shortage and Medicaid acceptance.[3,4] In 1984, Wiygul et al projected that Mississippi will need 1022 primary care physicians over the next 20 years to achieve a physician to population ration of 1:2000. With regard to Medicaid acceptance, present Mississippi figures reveal that 92.4% of the General Practice, Family Practice, Internal Medicine and Pediatric physicians accept Medicaid.[4] The American Medical Association reported that 79.2 percent of 6,000 physician of a national survey said they accepted all new Medicare patients in 1990. The largest decline was found among General/ Family practice physicians.[5] If Mississippi physicians decline in their acceptance of Medicaid and Medicare, access to care could be affected. Thus, the fact that Mississippi has a primary care physician shortage is not the only issue pertinent to access of primary care in Mississippi.

The purpose of this study was to investigate areas of physician practices which influence access to primary care. These areas included the number of physicians entering primary care and other specialties, Medicaid acceptance, patient load and possible retirement or relocation of practicing physicians within the next three years.

METHOD

Procedure - A questionnaire was designed to assess various factors thought to be related to accessibility to primary care. This questionnaire was mailed in 1990 to 1283 Family Practice, General Practice, Internal Medicine and Pediatric physicians who were members of the Mississippi State Medical Association. Responses from physicians who indicated that they were primary care physicians and in private practice were retained for further analysis. Program directors of primary care specialties at the University of Mississippi were asked to provide information concerning the number of physicians entering their programs since 1984.

Data Analysis - Each respondent was classified according to the public health districts of the Mississippi State Department of Health (see Figure 1). Categorical and interval scale variables were analyzed by chi-square and analysis of variance, respectively.

RESULTS

Five hundred twenty-six (40.9%) respondents returned completed questionnaires. Four hundred three of these physicians were primary care physicians and in private practice. Their data are analyzed in this study. The mean age of the sample was 48.5 (+/- 12.5 SD) years. Three hundred sixty-nine males and forty-four females partici-

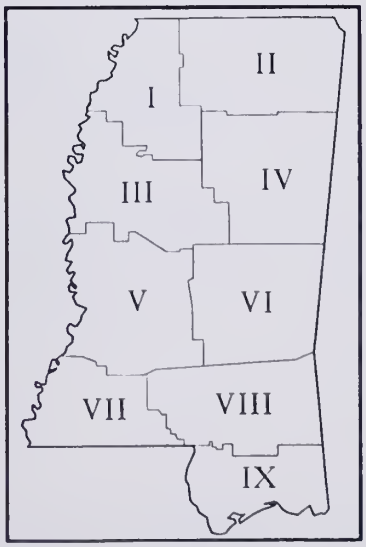


Figure I - Public Health Districts

pated in the study. Table I outlines their characteristics by public health district. The percentage of physicians accepting Medicaid within each health district is shown in Table II. Chi-square analysis resulted in X^2 (8) = 32.7, p< .01 indicating that when districts were compared, there was an unequal proportion of physicians accepting Medicaid. As can be seen in Table II, the relative proportion of Medicaid acceptance was high in District 1 and 3, moderately high in District 4 and low in District 5. Analysis of the proportion of physicians accepting Medicare by districts resulted in $X^2(8) = 10.5$, p> .05, indicating that there was an equal distribution of Medicare acceptance across districts. The percentage of physicians accepting Medicare state wide was 81.3%.

Table I - Demographics of Surveyed Physicians

District	Number of Physicians Responding	Mean Age	Sex Male	Female
1	23	52.4	16	7
2	43	49.9	40	3
3	34	50.7	31	3
4	41	49.7	39	2
5	92	46.0	84	8
6	37	49.0	35	2
7	36	51.4	35	1
8	43	48.1	39	4
9	47	45.5	44	3
	396 (7 missing)			

The percentage of physician indicating that their practices were at or over capacity was compared with the percentage of physicians who indicated that their practices were under capacity. The proportions of at or over practices are show in Table II. Chi-square analysis resulted in X2(8) = 17.8, p< .05, indicating that there was an unequal proportion of at or over capacity practices within the districts. As can be seen in Table II, Districts 4, 6 and 8 appear to have a relatively high proportion of at or over capacity practices. District 9 appears to have a relatively high proportion of under capacity practices.

The percentage of physicians who indicated that they would retire or relocate within the next 3 years is found in Table II. Chi-square analysis resulted in $X^2(8) = 22.9$ p< .01, indicating that when districts were compared, there was an unequal proportion of physicians who planned to retire or relocate. As can be seen in Table II, the relative proportions were relatively high in Districts 3, 6 and 7, and low in District 1. The number of physicians entering primary care residencies at the University of Mississippi is noted in Table III.

DISCUSSION

These data suggest that Mississippi has a problem with accessibility to primary medical care. At the current level of medical student interest in primary care residency programs will not be able to meet the demand projected by Wiygul et al. This problem is compounded by the percentage of physicians in Mississippi anticipating retiring or relocating in the next three years. District 3 had 44% of respondents indicating they would retire or relocate within the next three years. Since only 63% of practices are at or over capacity, many of the patients loosing their health care provider may be absorbed by the remaining physicians. But this many retiring or relocating physicians indicates a serious need to recruit new physicians or to improve the conditions influencing their decision. If this is not done, then a patient's accessibility to care and the quality of the care he receives may be compromised.

Table II - Factors Affecting Access to Primary Care by District

District	%Physicians Accepting Medicaid	%Physicians Accepting Medicare	% Practices At or over Capacity	%Retiring/ Relocating
1	95.5	90.9	60.9	9.5
2	85.4	73.8	62.8	14.3
3	96.9	87.5	62.5	44.1
4	92.1	82.1	82.5	12.8
5	63.0	74.4	58.9	14.6
6	83.3	80.3	86.5	27.8
7	83.3	76.5	61.1	31.4
8	85.7	90.2	71.4	14.3
9	83.0	88.4	55.3	17.4
Total	81.6	81.3	65.9	19.8

Table III - Primary Care Physicians in Mississippi Physicians Entering Training Programs 1984-1991

	Number	Average per Year
Family Medicine	106	13
Internal Medicine	131	16
Medical Pediatrics	7	1
OB-GYN	38	5
Pediatrics	70	9
Total	352	44

Source: Univeristy of Mississippi Medical Center, Department of Family Medicine, Department of Internal Medicine, Department of OB-GYN, Department of Pediatrics.

From the standpoint of patient load, only 65.9% of practices are at or over capacity. This should allow many patients to be absorbed by existing practices in each health district. Districts 4, 6 and 8 had higher proportions of practices at or over capacity than other districts. These districts will suffer the greatest impact when physicians retire or relocate, unless new physicians are attracted to the district. Also, District 9 had the highest proportion of under capacity practices in the state. This may suggest a maldistribution of physicians unless the population growth projection for the district is greater than projections for other health districts.

The number of physicians accepting Medicaid and Medicare implies that many patients who are unable to pay may lack access to medical care. Mississippi physicians do accept Medicare as often as the national sample; however, the relatively low Medicaid and Medicare acceptance rates leave a large group of uncovered patients. These patients probably will seek health care in hospital emergency rooms at the University Medical Center or other facilities. Encouragingly, some state and federal programs have recently improved access to primary care. For example, the Mississippi Postneonatal Death Impact Project, a joint project of the Mississippi Chapter of the America Academy of Pediatrics and the Mississippi State Health Department, increased the number of Medicaid eligible infants and children and decreased postneonatal mortality.[7]

It is difficult to make strong projections for the state of Mississippi from this survey because of the 40.9% response rate. Further, one fact that cannot be overlooked is the devotion of primary care physicians to their profession and patients. Physicians' offices are open for patient care a median of 45 hours per week, and physicians take a median of only 14 vacation days per year. These facts should lessen the impact of physician retirement and relocation.

This data can guide health care planners in addressing accessibility to care problems. Information, in addition to the physician/population ratio, can be given to physicians deciding on a practice location. This will better serve the financial needs of the physician and the primary care needs of the state.

With continuing communication between private physicians and the public sector, as well as research projects such as this study, more solutions can possibly be found to improve access to primary care despite existing overall physician shortages.❑

2500 North State Street
Jackson, MS 39216-4505

ACKNOWLEDGEMENTS

The authors would like to thank Ms. Mary Joyce Shelton for her technical assistance, Dr. Diane Beebe for her professional advise and Ms. Alice Brow for manuscript preparation.

REFERENCES

1. Newhouse JP. Geographic access to physician services. Ann Rev Public Health 1990; 11:207-30.
2. Steiner CB. Access to cancer prevention, detection and treatment. Cancer 1991; 67:1736-40.
3. Wiygul FM, Gillis WR. Primary care physicians in Mississippi. J Miss State Medical Assoc 1984; 25(3): 67-69.
4. Smith JC, Hartwig L, Laufer RH, Cole WQ, Larsen JG, Jackson AJ, Hill JE. Physician participation in the Mississippi Medicaid Program: 1989-1990. J Miss State Med Assoc 1991; 32(1): 1-8.
5. Larkin H. Medicare access may be slipping. American Medical News. 1991 July 29: pg. 9.
6. Barber J. Mississippi perinatal awareness project, Grant #MCJ-283809, Mississippi Department of Health, Jackson, MS 1986.
7. Abney RL, Weaver M, Montgomery C, Barber JK, Graves GR. Improving access to pediatric health care in Mississippi. J Miss State Med Assoc 1990; 31(10): 323-26.

*Dr. Ladner is a PGY -1 resident in Psychiatry, **Dr. Blake** is an associate professor and residency director Department of Family Medicine, and **William Replogle** is an associate professor, Department of Family Medicine all at the University of Mississippi Medical Center.*



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720

Laparoscopy For The Management Of Appendicitis

V. JOHN BAGNATO, MD

Laparoscopy is now widely accepted as the best approach for cholecystectomy. Laparoscopic cholecystectomy has been accepted rapidly because the visceral portion of the operation remains identical to the open procedure. Advantages of laparoscopic cholecystectomy are well established and include early recovery, less pain and cosmesis.[1] Laparoscopy is now being extended to other general surgical problems including appendicitis. However, controversy exists as to the exact role of laparoscopy in the diagnosis and treatment of patients with appendicitis. Surgeons are reluctant to routinely use laparoscopy for the treatment of inflammatory conditions such as appendicitis.[2] Presented is evidence to suggest routine laparoscopy for the diagnosis and management of patients with appendicitis.

MATERIALS AND METHODS

Twenty-three consecutive cases of right lower quadrant pain were treated with laparoscopy. Patients ranged in age from 13 to 62 years old (average 31). Ten patients were male and thirteen were females. The decision to perform an operation was not based on the use of laparoscopy. The patients were considered candidates for appendectomy using the usual criteria of history, physical findings and laboratory and radiographic data. The patients were placed supine on the table. The 10 mm 0° laparoscope was placed through the umbilicus. Video laparoscopy was used for all cases. The surgeon stood on the left of the patient with the video monitor on the right toward the foot of the table. No assistant surgeon was present. The surgical team consisted of a surgeon and two technicians. One ORT guided the scope and camera unit and the other ORT passed instruments. The series differed from the beginning toward the end by the addition of the endoscopic GIA (Auto Suture). A 10 mm port was placed in the superpubic region early in the series, but when the GIA became available, this port in the superpubic area was converted to a 12 mm port to accommodate the Endo GIA which goes through a 12 mm port. A 5 mm port was placed in the right lower quadrant (see Figure 1). If additional ports were needed they were placed in the left lower quadrant. The appendix was dissected free and either ligated with a loop ligature or divided using endoscopic GIA (USSC). The Mesoappendix was either treated with loop ligature, clips or the endoscopic GIA. The appendix was delivered through the abdominal wall using a sterile light handled cover which had been trimmed to allow for passage through the 12 mm port and to make retrieval from the abdominal cavity easier. The light handle cover seemed ideally suited since it is heavy plastic and has a conical shape. It keeps the appendix oriented longitudinally and is far superior to a sterile condom. The wounds were closed with subcuticular sutures. Drains were used when it was felt appropriate because of abscess formation.

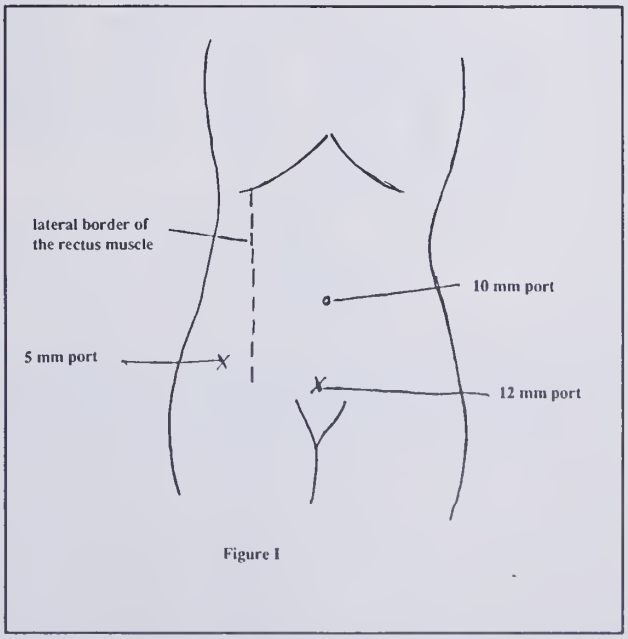


Figure 1 - Position of the 3 ports usually used for laparoscopic appendectomy. Additional ports are usually 5 mms in size and placed in the left lower quadrant.

RESULTS

One patient required conversion to an open or traditional appendectomy because of a large phlegmon. All other patients were treated laparoscopically. All patients except one had pathology found to explain the symptoms.

Five patients were found to have gynecologic pathology and therefore did not have an appendectomy. One patient had removal of an appendix which was histologically normal; however, her symptoms resolved with appendectomy. The seventeen remaining patients had histologic appendicitis (94% diagnostic accuracy). Six of these patients had perforation of the appendix. One postoperative pelvic abscess had been encountered. One minor abdominal wall cellulitis has been seen. No other complications have been encountered. The patients were usually discharged on the second or third hospital day. Average length of hospitalization was three days (range 1-18 days).

DISCUSSION

Laparoscopy for treatment of right lower quadrant pain has been used extensively in Europe with reported success.[3] However, there appears to be a general reluctance to use laparoscopy widely for right lower quadrant pain by American surgeons. There are several reasons to advocate laparoscopy for the surgical management of appendicitis. Firstly, the surgical management of right lower quadrant pain is obscure in a large percentage of patients. Laparoscopy aides in the diagnosis, as well as providing a mechanism of treatment of other abdominal conditions.[4] For instance five patients in this series were found to have gynecologic pathology which was treated primarily by laparoscopy. Two ruptured ovarian cysts were removed and two mittelschmerz phenomenon were seen which required no specific treatment. One patient was found to have pelvic inflammatory disease. Routine incidental appendectomy was not performed during laparoscopy in which other pathology was found to explain the patient's symptoms. This is somewhat controversial and will vary from surgeon to surgeon. Nevertheless, with the wide use of laparoscopy the accuracy of diagnosis of appendicitis in appendectomy specimens could approach 100%.

Secondly, the technical aspects of appendectomy are actually easier to perform laparoscopically. Surgeons widely use right lower quadrant incisions and frequently make these incisions as small as possible. The use of laparoscopy is very cosmetic but at the same time allows for a full range of options in treating acute appendicitis. Commonly the appendix is not in the right lower quadrant and poses difficulty when approached through a McBurney incision. For instance, retrocecal appendices are no more difficult to remove laparoscopically than an intra-abdominal appendix. The cecum can usually be mobilized quite easily. The presence of edema makes the plane of dissection actually easier. Retrocecal appendices pose a significant problem through a McBurney incision and frequently require the incision to be enlarged. However, no significant adjustment is necessary in the laparoscopy because of the position of the appendix.

Additionally, full abdominal and pelvic exploration can be performed without adding morbidity. The entire peritoneal cavity is accessible with the laparoscope placed at the umbilicus. Furthermore, when other pathology is found, it is usually amenable to laparoscopic treatment without adding morbidity, as might occur when an incision is enlarged, particularly if a McBurney incision is enlarged to gain exposure of the ovaries.

The use of the endoscopic GIA (USSC) makes the appendectomy very expeditious and safe. Once the appendiceal stump is identified the GIA is used to divide it securely. Three staple lines securely ligate the appendiceal stump. The mesoappendix is handles as needed with either clips, loop ligatures or the endo GIA (USSC) with the vascular V3 Cartridge. Laparoscopic appendectomy performed with the endo GIA is probably faster than an open appendectomy and certainly more cosmetic.

Additionally laparoscopic appendectomy is frequently associated with less morbidity. Elderly patients and obese patients frequently have co-morbid conditions or harbor other more sinister colonic conditions. Because of uncertainty in the diagnosis, a midline incision is frequently made in elderly patients with possible appendicitis. Furthermore, obesity poses a significant technical problem through the standard McBurney incision. With the use of laparoscopy a midline incision can be avoided until it is absolutely necessary. This results in significant reduction of morbidity, as a significant percentage of these patients will indeed have appendicitis that can be treated laparoscopically.

There is little doubt that in patients with co-morbid conditions, the elderly and obese patients laparoscopy will be better tolerated and associated with a shorter and more pleasant recuperation than laparotomy. In young otherwise healthy patients, laparoscopic appendectomy is more cosmetic. Therefore, there is nothing to be lost by attempting laparoscopic appendectomy. Laparoscopy will frequently yield a more accurate diagnosis and provide for a better planned procedure.

CONCLUSION

Perhaps it is best to ask the question "Why should laparoscopy not be used for the treatment of appendici-

tis?" The renaissance in general surgery that has been created by the use of laparoscopy is advantageous to both patients and surgeons. However, it was patient consumerism demonstrated by demanding laparoscopic cholecystectomy that caused the rapidity in which general surgeons embraced laparoscopy. Appendectomy is an emergency operation and, therefore, patients do not electively seek laparoscopic surgery. However, the advantages of laparoscopy are clear both to the surgeon and to the patient. Laparoscopy can be used in the definitive diagnosis and treatment of appendicitis. The increased accuracy of diagnosis combined with the advantages of less pain, cosmesis, and rapid return to normal activity are significant, albeit not as significant as the advantages of laparoscopy for the treatment of cholelithiasis. Nevertheless, for selected patients, those who are obese or have co-morbid conditions or in whom the diagnosis is not clear, laparoscopy offers a definite and significant benefit. The advantages should provide enough benefit to the surgeon to outweigh any inconvenience caused by emergency laparoscopy. The reduction in morbidity is not only directly beneficial to the patient but also the surgeon caretaker. Less morbid operations make for patients who are easier to care for postoperatively. It is expected as laparoscopy increases in popularity, the use of laparoscopy for the treatment of patients with right lower quadrant pain will become standard. ❑

105 Asbury Circle
Hattiesburg, MS 39404-6149

REFERENCES

1 Reddick EJ, Olsen DO. Laparoscopic laser cholecystectomy. *Surg Endosc* 1989;131-133
2. Saye WB, Rives DA, Cochran EB. Laparoscopic Appendectomy: Three Years' Experience. *Surgical Laparoscopy & Endoscopy* 1991;1:109-115
3. Semm K. Endoscopic Appendectomy. *Endoscopy* 1983;15:59-64
4. Horsch RF. Laparoscopy in the diagnosis of acute appendicitis. *Contemporary Surgery* 1989;34:11-16
5. Pier A, Gotz F, Bacher C. Laparoscopic Appendectomy inn 625 cases: From Innovation to Routine. *Surgical Laparoscopy & Endoscopy* 1991;1: 8-13

Dr. Bagnato is associated with the Surgery Clinic of Hattiesburg.

COME SEE THE BEAUTIFUL NEW MODELS NOW!

HARRELD
CANTON

Member of CENTRAL MISSISSIPPI Chevy Dealers

CALL US 1-800-451-3908 TOLL FREE!

MISSISSIPPI'S FAVORITE COMBINATION CHEVY-OLDS-GEO DEALER

HARRELD CHEVY-OLDS-GEO

Canton 859-1611 Highway 51 South - Canton, MS Jackson 354-2233



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

Mississippi Comprehensive Health Insurance Risk Pool Association

Certain uninsurable residents of Mississippi now have the opportunity to purchase health insurance. The Mississippi Comprehensive Health Insurance Risk Pool Association, established by the Mississippi Legislature in 1991 for the purpose of making such coverage available, became operational in January of this year.

Previously, health insurance benefits have been available only through private insurance carriers and public programs such as Medicare and Medicaid. Those persons not provided health insurance via employment or government programs have found it necessary to purchase individual policies. However, obtaining individual insurance has been virtually impossible or cost prohibitive for many with congenital or chronic disorders.

The manner in which medical care insurance is made available to the uninsured and uninsurable is a dilemma currently facing both politicians and society as a whole. Individual states are making efforts to assure that medical insurance can be obtained by those who do not now have health insurance coverage available to them. The two most common vehicles for accomplishing this are "bare-bones" type coverage, which costs substantially less than conventional medical insurance, and high risk pools, which offer coverage to those who can afford insurance but cannot obtain it due to health conditions.

With the establishment of the Mississippi Comprehensive Health Insurance Risk Pool Association, Mississippi became one of approximately twenty-five states to implement such a program. Of the states adjoining Mississippi, only Tennessee has such a program operational. Louisiana enacted similar legislation in 1990, but the Louisiana program is not yet operational. The Mississippi Comprehensive Health Insurance Risk Pool Association is comprised of licensed health insurance companies, non-profit health services organizations operating in Mississippi and third party administrators. The Association is governed by a board composed of directors appointed by the membership of the Association and the Mississippi Commissioner of Insurance. At least one appointee to the board is required by law to be a member of the medical profession, and the MSMA President-elect Dr. Don Mitchell was appointed to this position. The Chair of the Mississippi Senate Insurance Committee and the Chair of the Mississippi House Insurance Committee are ex officio members of the board.

The Association currently offers a $250,000 lifetime maximum major medical policy with a choice of a $1,000 or $2,000 annual deductible. After the deductible is met, the Association policy generally pays 80 percent of covered claims. In some cases the policy pays more than 80 percent and in others less. Pre-existing conditions are excluded from coverage for the first twelve months of continuous coverage under the plan. Premium rates are based on age and sex, and they are typically higher than premium rates charged by conventional insurance companies for similar benefits.

To qualify for participation in the program offered by the Comprehensive Health Insurance Risk Pool Association, an individual must have been a legal resident of Mississippi for twenty-four consecutive months, must have been turned down for similar coverage by three licensed insurance companies and must not

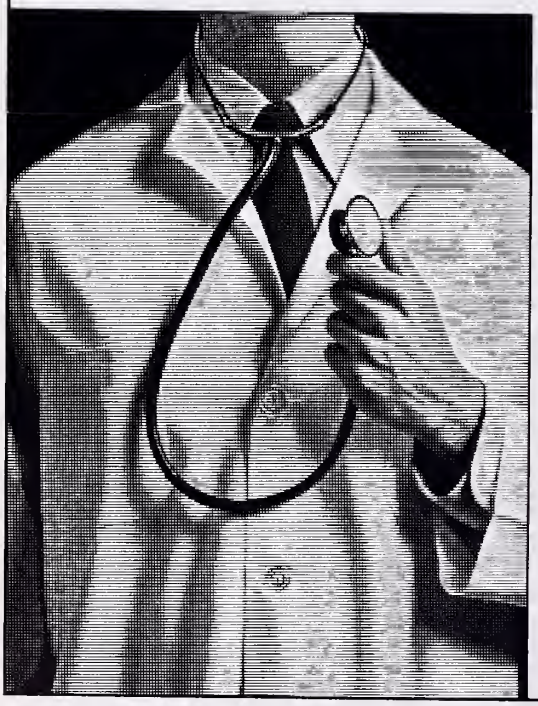
be eligible for other types of coverage, i.e., Medicare, Medicaid, employer group. Policies are issued as single coverage only. No family coverage is available, and there are no maternity benefits.

Funding for this program is not provided by the state. The Comprehensive Health Insurance Risk Pool Association derives funds for payment of benefits from premiums collected from its policyholders and quarterly assessments made against insurance companies, non-profit health care services organizations and third party administrators.

Adequate health care for all Mississippians is one of the most important objectives of the Mississippi State Medical Association, which has developed a series of recommendations in "Health Access Mississippi" to address this critical issue. Mississippi has frequently been criticized for lagging behind other states in addressing critical social issues. This is not the case with the establishment of the Mississippi Comprehensive Health Insurance Risk Pool Association. The program of insurance made available by the Mississippi Comprehensive Health Insurance Risk Pool Association is not a cure-all solution, and the program is not for everyone. It is coverage of last resort -- to help those who need it and can afford it obtain adequate medical care. ❑

For further information contact the Mississippi Comprehensive Health Insurance Risk Pool Association, PO Box 13748, Jackson, MS 39236, (601) 362-0799.

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect .

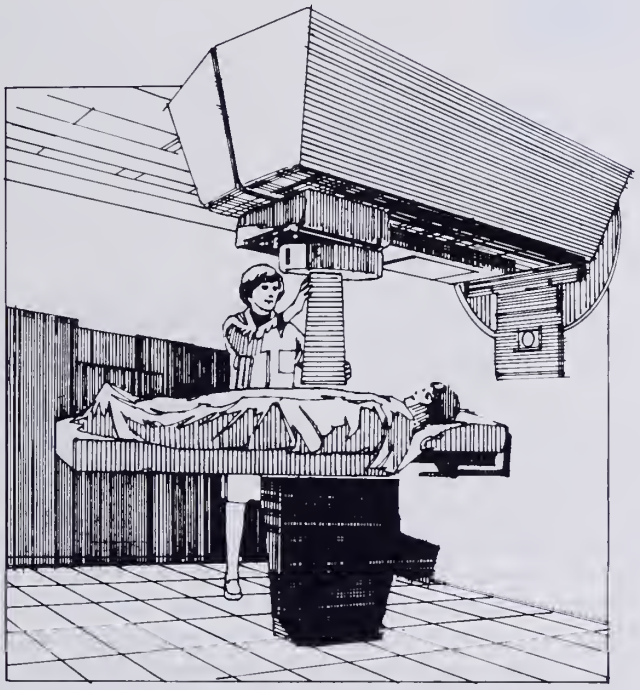
ARMY HEALTH CARE TEAM

(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251



The President's Page

WILLIAM C. GATES, MD

"Pondering Professionalism - Profit and Piracy or Priesthood and Philanthropy?"

As promised in the first two installments of the President's Page, I will continue to write about some of the very basics of the practice of medicine; the things in my opinion that make our *profession* unique and great. ***Professionalism*** is one of these attributes.

What is professionalism? Dr. John Ring, President of the AMA, says it has three essential elements: competence, ethics and compassion. He went on to say that the bedrock of medicine's professionalism is to "put the patient first". What does that mean? Dr. James Todd, Executive Vice-President of the AMA, said in an editorial in the December '91 *JAMA* that "every physician-patient encounter is a conflict of interest. Every physician-payor encounter is also a conflict of interest. Traditionally, these conflicts have been settled purposefully in society's favor. Most, we believe, still are." He stressed the principles of "honesty, competence and self-regulation" as benchmark.

In a letter to FTC Chairman Janet Steiger, Dr. Joseph T. Painter (in-coming president-elect of AMA) and Dr. Todd state that "physicians do not claim to be above the rules of human nature, but their occupation requires that they assume the special status of a fiduciary - a role at odds with the pure market player. They see patients when at their most exposed and vulnerable state. Patients must trust their physicians and believe that where the conflict exists, the patient's interests will be placed above the physician's own interest."

In Report: BBB (I-91) of the AMA Board of Trustees, it is stated that "the heart of professionalism is adherence to a set of standards - a code of behavior - which is higher than civil law or the marketplace require."

In an April 30, 1992, letter to the Federation from the AMA, it was stated that "public esteem and trust are great rewards of the practice of medicine" and "the profession has earned this trust in large part by establishing standards of education, organization, ethics and medical practice which physicians adhere to even where the law or marketplace require less" (*vide supra*). Additionally, it was noted that "the profession has created a remarkable structure for self-regulation. The accreditation agencies, the hospital medical staffs, and professional associations represent a vast network of physicians, the bulk of whom are volunteers, who are actively involved in self-regulation every day. In addition, physicians pay a substantial amount

(Continued on page 257)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 7
JULY 1992

To the Editors *Journal MSMA*:

As one who handles advertising for my company, I receive a copy of the *Journal* every month. Normally I scan through it to see our advertisement and then put it in a stack of other periodicals I keep in my office. Never do I attempt to read it because with my "car salesman" mentality I only understand small words ... not the medical jargon that physicians use.

However, in the May issue, I, for some unknown reason, read several of the articles. In doing so, I was amazed at the attention given to patient care and the rigid ethical standards set forth for physicians by their own associations and organizations. I was particularly touched by the article written by Dr. Dwalia South entitled *Feeling Like a Real Doctor Again.*

I have spent most of the past twenty-one years dealing with doctors and their transportation needs. For the most part, I have found them to be considerate, courteous, reputable and sensitive people. I have often wondered how they can appear confident and capable with every patient they see, day in and day out and often at night. It takes a special type person to dedicate his or her life to the care of others and they in turn, should be ... and deserve to be treated special.

Certainly doctors get paid well for their services, but how many of us in the general population would dedicate so much of our lives to any cause ... regardless of the pay involved?

My hat's off to the fine physicians of this state and I have great appreciation for what they do. I'd hate to live here without them.

Sincerely,
Brian King
Fleet & Leasing Manager
Harreld Chevrolet Company

Presidents's Page

(Continued from page 256)

of dues to finance those activities - - the buildings, the meetings, the publications, the travel and staff needed to make it operate."

Dr. Todd reminds us (*JAMA* December '91) that we will not achieve perfection even though striving to instill a strong sense of duty and professionalism in practitioners and that it would not be appropriate to assume that all physicians are ethical, honest and competent. He also noted that "it is always easy to spotlight anecdotal cases of deviate behavior: good news does not sell newspapers! So, we are bombarded with accounts of gross incompetence, greed, and fraud against both patients and institutions." The media and our critics often attempt extrapolation to quantify the bad behavior, and exaggeration results along with the cries of "profit and piracy."

We, in turn, would like for the numbers to be small and have our priests and philanthropists vastly outnumber the profiteers and pirates. I sincerely believe that is the case and that the priesthood of medicine is alive and well. We just need a renewed commitment of our professionalism and a resolve to enforce our code of ethics and ferret out those individuals who would serve themselves at the expense of others. Please join me and your AMA in rededicating ourselves to the principles of professionalism.

I hope my note finds you and yours doing well.....

Best Regards,
Bill

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

THE UNITED STATES ARMY RESERVE

HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

"Current Opinions"

of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON SOCIAL POLICY ISSUES

Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate cardiopulmonary resuscitation (CPR) would be futile or not in accord with the desires or best interests of the patient.

Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR and this should be documented in the patient's medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's preferences regarding the use of CPR.

If a patient is incapable of rendering a decision regarding the use of CPR, a decision may be made by a surrogate decisionmaker, based upon the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests.

If, in the judgment of the treating physician, CPR would be futile, the treating physician may enter a do-not-resuscitate order into the patient's record. Resuscitative efforts should be considered futile if they cannot be expected either to restore cardiac or respiratory function to the patient or to achieve the expressed goals of the informed patient. When there is adequate time to do so, the physician must first inform the patient, or the incompetent patient's surrogate, of the content of the DNR order, as well as the basis for its implementation. The physician also should be prepared to discuss appropriate alternatives, such as obtaining a second opinion (e.g., consulting a bioethics committee) or arranging for transfer of care to another physician.

Do-not-resuscitate orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient. ❑



Medical Organization

Governor Fordice Speakes to Jones County Medical Dental Independent Practice Association



On May 27, 1992 Mississippi Governor Kirk Fordice spoke at the quarterly meeting of the Jones County Medical Dental Independent Practice Association (MDIPA). Dr. John M. Wallace of Laurel, current president of the association, served as chairman.

Approximately eighty physicians, dentist, and community leaders attended the luncheon meeting held at the Lauren Rogers Museum in Laurel.

The Governor's topic was education in Mississippi. He specifically addressed the National Education initiatives for the year 2000 which are being incorporated in the state's education plan. These initiatives have also been adopted by the local community as part of Laurel 2000 and include the following: 1). All children will start to school ready to learn. 2). A 90% graduation rate for all high school students. 3). Students will be tested at the 4, 6, 8, and 12th grade levels for competency. 4). Students will be 1st in the world in the sciences and math. 5). Every adult literate. 6). Every school free of drugs and violence.

The Governor pointed out that for these goals to be accomplished the community was going to have to become involved in the public schools once again. He commended the Jones County Medical Dental Indpendent Practice Association for their continued interest in and monetary support of education in their local schools.

At the conclusion of the luncheon, Dr. Wallace made a $5,000 contribution from the MDIPA to Mr. Joe Sanders for the **Association for Excellence in Education**. Dr. Jimmy Waites presented Mr. Sanders another check for the **Association for Excellence in Education** from a fund raising project the MDIPA held. ❑



Dr. John Wallace, left, presents check to Mr. Joe Sanders.



Dr. Jimmy Waites, right, presents check to Mr. Joe Sanders.

From the University of Mississippi Medical Center

Faculty Appointments at UMC

Twenty-three faculty members in the School of Medicine have received promotions at the University of Mississippi Medical Center.

UMC Vice Chancellor Dr. Norman C. Nelson announced the promotions, effective July 1, following approval by the Board of Trustees of State Institutions of Higher Learning.

Promoted to the rank of professor in the medical school were **Dr. Patricia Dubbert** (psychiatry), **Dr. Joe C. Files** (medicine), **Dr. Michael LeBlanc** (pediatrics), **Dr. Walter Kruckeberg** and **Dr. William Lushbaugh** (preventive medicine).

Medical school faculty promoted to associate professor included **Dr. Michael Andrew** (preventive medicine), **Dr. Michael Bross** (family medicine), **Dr. David Dzielak** (surgery), **Dr. Mary Bradley Coleman**, **Dr. Cheryl Hardy**, **Dr. Richard Terry Jackson** and **Dr. Thomas Skelton** (medicine), **Dr. Rick Martin** (ob-gyn) and **Dr. Charu Subramony** (pathology).

Dr. Twila Massingale (pediatrics), **Dr. Thomas Mosely** and **Dr. Henry Christmas Waterer III** (medicine), and **Dr. Claude Darnell Brunson** (anesthesiology) were promoted to assistant professor in the medical school.

Centerwide promotions to associate professor included **Dr. David Bernanke** (anatomy), **Dr. John J. Correia** (biochemistry), **Dr. David Bruce Couch** and **Dr. Patrick McCaslin** (pharmacology and toxicology) and **Dr. Norman Miller** (microbiology).

Dr. Dubbert, a clinical psychologist, has been on the UMC faculty since 1981 and is the chief of psychology at the Department of Veterans Affairs Medical Center. She holds the PhD from Rutgers University.

A hematologist and member of the faculty since 1979, Dr. Files holds the MD from UMC and completed a fellowship in hematology at the University of Washington School of Medicine in Seattle.

Dr. LeBlanc's primary research interest is in blood disorders of newborns. He earned the MD at the University of Alabama and was an National Institutes of Health (NIH) research fellow at Children's Hospital Medical Center in Cincinnati. He has been on the UMC faculty since 1981.

Dr. Kruckeberg directs the biochemical genetics testing laboratory at UMC. A faculty member since 1978, he holds the PhD from Washington University, St. Louis, and was an NIH trainee at the University of Michigan.

A member of the faculty since 1983, Dr. Lushbaugh is a medical parasitologist. He holds the PhD in tropical medicine and parasitology from Louisiana State University in New Orleans. ❑

The Delta Region AIDS Education and Training Center grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN,
Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street,
Jackson, MS 39216-4505

Electronic Bulletin Board and Library Services Available Through MisHin at UMC

As a health professional in the state of Mississippi you are invited to become a member of the Mississippi Health Sciences Information Network (**MisHIN**). The network is a decentralized system of multitype libraries and other information providers designed to bring information resources to health professionals who do not have ready access to a medical library. State-of-the-art electronic communication technologies provide health professionals with direct access to health sciences information resources within the state as well as to other national databases. MisHIN's primary purpose is to serve as coordinator for electronic health sciences information transfer in Mississippi.

The network was established in 1989 through a pilot project, funded by a subcontract with the University of Maryland through the Southeastern/Atlantic Medical Library Services contract with the National Library of Medicine. With headquarters at Rowland Medical Library at UMC in Jackson, the network provides access to **EASYLINK**, and electronic mail/bulletin board system; **RoMeO**, Rowland's online catalog; training seminars in the basics of microcomputer operations and **GRATEFUL MED**, a software gateway to search for journal articles on **MEDLINE**; and direct library services from five participating network libraries.

MisHIN libraries provide traditional library services directly to the health professional unaffiliated with a health science library on a fee basis. Request for library information my be made by phone, mail, electronic mail or telefacsimile. Requests for information not owned in the state are referred to regional and national libraries upon the requestor's authorization.

Other MisHIN programs require a microcomputer, modem, and dedicated telephone line. Communications software and a 2-hour instructional workshop in basic microcomputer operations are provided by MisHIN. Likewise, GRATEFUL MED software and instruction are offered in a 3-hour workshop. CME credits are available for both workshops. Through these programs MisHIN members will not only learn to search MEDLINE using GRATEFUL MED, but will learn to use their computers to dial into EASYLINK, RoMeO and other databases. The training sessions, with software installation, are conducted on site in the MisHIN members's office if desired.

EASYLINK mail service offers individuals the capability of electronic communications for consultations and messages without the frustration of unanswered or missed phone calls. The electronic bulletin boards include a list of consultants from the faculty of the University Medical Center, a list of MisHIN members, a directory of continuing medical education activities, the full text of NIH's Clinical Alerts, and MisHIN news.

MisHIN members have computer access to RoMeO, the online catalog of the Rowland Medical Library, to identify book and journal holdings. This provides rapid verification of needed information sources.

The network is designed as a system which utilizes electronic communications as the basis for information access and delivery. Library services are available with or without electronic capabilities.

For additional information, please call MisHIN headquarters at 1-800-782-6988 or in the Jackson area, 984-1290.



***Gruich Recognized At UMC** - Mitchell Joseph Gruich of Biloxi, left, the son of Mr. And Mrs. Mitchell J. Gurich, Sr., was selected Medical Student of the Year by his fellow senior medical students and was recognized during School of Medicine awards day ceremonies at the University of Mississippi Medical Center in Jackson. Dr. Norman C. Nelson, right, is UMC vice chancellor and dean of the medical school. The student of the year award is sponsored by the Medical Alumni Chapter of the University of Mississippi Alumni Association and recognizes the person demonstrating "those qualities most desired in a physician."*



MISSISSIPPI STATE MEDICAL ASSOCIATION

MSMA Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE

The MSMA provides a toll free WATS for any member to call to inquire about programs and policies of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

LIAISON SERVICES

MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE

MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. All MSMA members are also eligible to apply for health insurance programs offered by the American Medical Association. For information contact Jackye Wiebelt at MSMA Diversified Services, Inc.

PRACTICE MANAGEMENT

Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Weibelt at MSMA Diversified Services, Inc.

BUSINESS AND PERSONAL INSURANCE

The MS Physicians Insurance Company (MPIC) through its managing general agency, Evans and Giordano, offers a wide range of low cost business and personal insurance for members of the association. MPIC has a Board of Directors appointed by MSMA composed entirely of practicing physicians who with the advise and assistance of Evans and Giordano seek to identify the special insurance needs of physicians. For further information call Evans and Giordano.

DEBT COLLECTION SERVICE

Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call Robert Kidd at MSMA.

FINANCIAL/RETIREMENT PLANNING

MSMA members by virtue of their membership in the AMA are eligible to participate in AMA Investment Advisors, Inc. This wholly owned investment subsidiary of the AMA offers a wide range of investment opportunities tailored specifically for physicians. For further information call AMA Advisers.

MEDICAL MALPRACTICE INSURANCE

The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible members of the association. More than 1500 Mississippi physicians are currently insured by MACM and extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-534-5433 or 800-898-0251 (In-State-WATS).

AMA Advisers - 200 N. LaSalle Street, #535, Chicago, IL 60601, 800-525-0864.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - (Evans and Giordano, Managing General Agency) - P.O. Box 12978, Jackson, MS 39296-2978, 601-957-5100 or 800-748-9713 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-200 or 800-325-4712 (In -State-WATS).

What employers — like doctors — are asking Employer Plus.

Q. ***Should an employer provide benefits for employees, or just give them a raise in pay and let them fend for themselves?***

A. *If a pay raise is given, it will cost you as the employer additional dollars by increasing the employer matching social security taxes and increasing worker's compensation premiums. However, if you provide them with employer paid benefits, you will not incur these additional costs.*

Q. ***Will my employees settle for benefits rather than pay increases?***

A. *A study done by the Harvard Business School during the late 80's found that employees rated increased benefits as the next best thing to a raise in pay.*

How Employer Plus can help!

Good benefits help to retain good employees. And, if you split the cost of the benefits with the employees, both of you will come out ahead.

Here's why.

Employer Plus offer our clients an IRS Qualified "Section 125 Cafeteria Plan" for their employees' benefits plan. This plan allows each employer to withhold a portion of its employees' salary to be used to pay for insurance premiums, medical expenses, dependent care, and savings for retirement. The amount that each employee sets aside from their salary to pay for these benefits is tax exempt from FICA Withholdings, Federal Income Tax Withholdings and State Income Tax Withholdings.

In doing this, a bigger take-home amount is produced for your employees, even though you the employer have not actually given them a raise. The increase simply comes from the amount that employees' were paying the government in tax dollars.

Here is just a sample of the benefits that Employer Plus offers our clients in our Cafeteria Plan. All of these benefits are with top-of-the-line, national companies:

- **Health Insurance**
- **Dental Insurance**
- **Vision Insurance**
- **Disability Income Insurance**
- **Life Insurance**
- **Dependent Care**
- **Medical Reimbursement**
- **Retirement Plans**
- ***... and more***

Employer Plus has saved the best part for last...

Our Cafeteria plan will lower your labor cost. For every dollar that your employees run through the Cafeteria Plan — you the employer — will save 7.65%, because you will not have to pay the employer matching share of social security tax. Also, worker's compensation premiums are not calculated on benefit bonuses.

If you are interested in giving more to your employees — and taking home more money from your practice — give us a call.

We have many ways we can save you money!



Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.

Personals

Paul M. Allen, MD of Pascagoula has been notified by the American Urogynecologic Society that he has been selected as a coinvestigator in a collaborative research project on Urethral Syndrome.

Robert E. Bailey , a neurologist has joined the staff of Rush Medical Group, PA. of Meridian.

Kyle Bateman announces the opeing of his practice of family medicine 425 Hwy. 51 North, Brookhaven.

C. Ralph Daniel, III of Jackson recently spoke in New York on nail disorders.

Joseph W. Farina, Jr. of Meridian announces the relocation of his office to The Meridian Neurology and Headache Center, 1216 25th Avenue.

Richard J. Field, Jr of Centreville represented the American College of Surgeons at the American Association of Pediatric Surgery annual meeting in Colorado Springs. He also served as visiting Professor of Surgery at the James Quillan School of Medicine at East Tennessee State University in Johnson City.

Charles E. Guice of Hattiesburg was recently honored by the Hattiesburg Clinic with a luncheon in recognition of his retirement earlier this year. Dr. Guice, a surgeon and one of the 13 founding physicians, joined the group practice in 1961 that officially became Hattiesburg Clinic in May 1963. Also attending the luncheon were: **Dr. William Raulston, Dr. Richard Clark, Dr. Lamar Gillespie, Dr. Glen Pearson, Dr. Fred Tatum, Dr. Ramsay O'Neal, Dr. Gerald Gable, and Dr.**



FLIGHT SURGEONS WANTED.

Discover the thrill of flying, the end of paperwork and the enjoyment of a general practice as an Air Force flight surgeon. Take flight with today's Air Force and discover quality benefits, 30 days of vacation with pay each year and the support of a dedicated staff of professionals. Enjoy a true general practice on the ground, with the kind of stimulating challenge that will get your medical skills airborne. Talk to an Air Force medical program manager about becoming an Air Force flight surgeon. Call

USAF HEALTH PROFESSIONS
TOLL FREE 1-800-423-USAF

AIR FORCE

Personals/continued

D. B. Conerly all founding physicians of the Clinic.

John R. Harper of Taylorsville recently completed a University of Alabama at Birmingham (UAB) continuing medical education course on key disorders and controversial issues in gastroenterology.

Stephen P. Johnson announces his association with Daniel J. Peasley at the Gastroenterology Clinic, 319 South 13th Avenue, Laurel.

Thomas E. Joiner of Jackson announces the opening of his solo practice in Family and Industrial Medicine at 4613 Clinton Boulevard.

Robert Jordan of Meridian , a family practitioner, has relocated his office practice to the Rush Family Medical Center at College Park.

Ursha Mehta has opened her private practice of obstetrics and gynecology in Baptist Memorial Hospital - DeSoto's Physician's Office Building in Southaven.

Francis Morrison of Jackson recently represented North American as a Councillor at the meeting of the World Apheresis Association in Sapporo, Japan. While at this International Congress, he Chaired a session on *Complications of Apheresis* and presented a paper on the subject.

John C. Mutziger announces the relocation of his Family Practice from Decatur to The Poplar Springs Family Medical Center, 4707 Poplar Springs Drive, Meridain.

Yoshinobu Namihira a physician with Better-Living Medical Clinic of Vicksburg, has been named a Fellow of the American College of Gastroenterology.

John M Searles, Jr has associated with Plastic Surgery Associates in Jackson for the practice of Plastic and Reconstructive Surgery, Hand Surgery, Cosmetic Surgery and Head & Neck Surgery, Lakeland Drive.

Francis Selmon of Pascagoula was the guest speaker for a meeting of the Jackson County Area Cancer Support Group held in the JF Turner Outpatient Surgical Center on the Singing River Hospital Campus.

Douglas N. Smith , a family practictioner, has announced that he will begin practicing with Rush Medical Group, PA of Meridian.

FOR INVESTMENT PERFORMANCE - WE'RE #1

33.3%* AVERAGE ANNUAL NET RETURN FOR PAST 5 YEARS

*MONEY MANAGER REVIEW RANKS CAMBRIDGE EQUITY ADVISORS THE **#1** PERFORMING MONEY MANAGER IN THE COUNTRY THE PAST FIVE YEARS

*AN INITIAL **$100,000** INVESTMENT ON OCTOBER 21, 1985 WOULD BE WORTH **$643,824** THROUGH MARCH 31, 1992

*INDIVIDUALLY MANAGED PORTFOLIOS HAVE INCLUDED STOCKS LIKE HOME DEPOT, U.S. SURGICAL, AMGEN AND WAL-MART

*WE MANAGE PERSONAL AND RETIREMENT ACCOUNTS AND CAN PROVIDE PHYSICIAN REFERENCES UPON REQUEST

CALL OR WRITE FOR MORE INFORMATION

CAMBRIDGE EQUITY ADVISORS

5214 MARYLAND WAY, SUITE 309, BRENTWOOD, TENNESSEE 37027

(800) 426-1391 (615) 371-9002

RATE OF RETURN IS CALCULATED ON TIME-WEIGHTED BASIS AND IS NET OF ALL FEES AND COMMISSIONS. RESULTS INCLUDE REINVESTMENT OF INCOME. RETURNS PRIOR TO JAN 1, 1990 FROM AUDITED MODEL PORTFOLIO AND THOSE AFTER THIS DATE ARE ACTUAL ACCOUNTS MANAGED OVER $100,000. PAST PERFORMANCE IS NO GUARANTEE OF FUTURE CONTINUED PERFORMANCE.

Robert Smith of Jackson was recently honored for his service in medicine by the Jackson Urban League African-American Awards Program. The purpose of the awards program was to highlight the contributions of individuals to their respective professions and the Mississippi Community.

Ed Thompson Mississippi State Epidemiologist became president of the national Council of State and Territorial Epidemiologists (CSTE) at their meeting in New Orleans in May. ❑

Physicians' Recognition Award



Five MSMA members were named recipients of the AMA Physicians' Recognition Award in May 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These five individuals are presented below by medical society.

Amite -Wilkinson
Medical Society
Jack Quin Causey, MD

Central
Medical Society
W. Wilson Defore, MD

Delta
Medical Society
Michael Joseph Cirilli, MD
Orby Lynn Hablin, MD
James Steele Robbins, MD

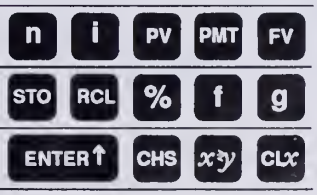
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- No-Load Mutual Funds/Other Securities
- 23 Years Experience
- Tested Asset Allocation Model
- Fee-Only Advisor

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123

PAIN MANAGEMENT

The multi-disciplinary treatment team at the Rehabilitation Institute of New Orleans offers comprehensive evaluation and treatment of pain in an inpatient or outpatient setting.

The following services are offered in the Rehabilitation Institute of New Orleans Pain Unit:

- Comprehensive Evaluations
- Work Capacity Evaluation
- Work Hardening
- Physical Therapy
- Occupational Therapy
- VOC
- Nursing
- Recreational Therapy
- Psychology
- Bio Feedback
- Stress Management
- Nerve Blocks

RINO

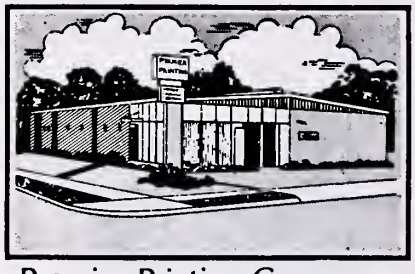
REHABILITATION INSTITUTE OF NEW ORLEANS
AT F. EDWARD HEBERT HOSPITAL

TELEPHONE:
(504) 363-2200
TOLL-FREE:
1 – 800 – 426-3085

One Sanctuary Drive ▪ New Orleans, Louisiana 70114
REHAB DIVISION OF NME

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

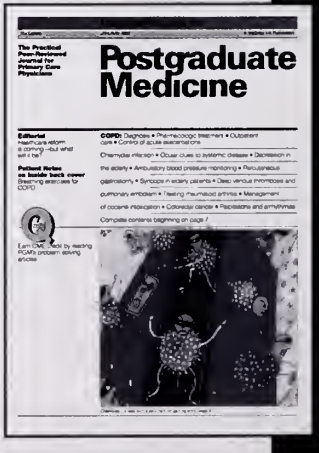
2485 West Capitol **Jackson, Mississippi**

Phone 352-4091

US THEM







WHEN YOU NEED TIME ON YOUR SIDE, THE CHOICE IS CLEAR.

NO CLINICAL CLUTTER– PGM ARTICLES ARE CLEAR, CONCISE, WELL ILLUSTRATED, AND PRACTICAL.

Postgraduate Medicine



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

A Risk Retention Group

MSMA-SPONSORED
Standard Insurance Claims Forms
HCFA 1500

		Member Price Per Carton	Non-Member Price Per Carton
☐	• Old two-part snap-out, NCR Form - 1000/carton		
	or		
☐	★ NEW two-part snap-out, NCR Form - 1000/carton		
Number of Cartons Requested			
☐		$37.25 Plus State Sales Tax	$45.00 Plus State Sales Tax

		Member Price Per Carton	Non-Member Price Per Carton
☐	• Old two-part continuous, NCR Form - 1000/carton		
	or		
☐	★ NEW two-part continuous, NCR Form - 1000/carton		
Number of Cartons Requested			
☐		$39.00 Plus State Sales Tax	$47.00 Plus State Sales Tax

- **All orders plus 6% Mississippi Sales Tax unless your organization is tax exempt**
- **Price includes all delivery and handling costs**
- **Rapid Shipment via UPS**

ORDER INFORMATION

RETURN ORDER BLANK TO:

Order Department - Insurance Forms
Mississippi State Medical Association
PO Box 5229
Jackson, MS 39296-5229

Call in orders:

(Toll Free In-State Wats)	1-800-898-0251
Jackson and surrounding area	354-5433
MSMA Fax Number	352-4834

SHIP ORDER TO:

_____
_____
_____
_____
(Please indicate street address and zip code)

_____
(name of individual placing order)

_____
(purchase order #)

_____
(phone #)

Placement Service

Family Practice/ ER Physician needed on a regular weekday basis (15 to 20 hours a week) and to work alternate Saturday's. North East Jackson. Call 957-2273.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Tired of Working for Someone Else With No Chance for Ownership?

Excellent opportunities for career-oriented Emergency Physicians. *Ownership Opportunities.* Local physician-owned and managed group with contracts in North, Central, and Southcentral Mississippi with potential income of $200,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Positions available now.

Please send your CV to:
PO Box 13849, Jackson, MS 39236-3849
or call Sheila M. Harkins, at (800) 844-6503
Mississippi Emergency Association, PA

FP, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

Greater Meridian Health Clinic is seeking a Medical Director. The Director will manage an experienced and enthusiastic management team in the area of primary care delivery. Responsibilities include: provider supervision and scheduling, planning, implementation and evaluation of medical services, and oversight of quality assurance programs. Candidates should be Mississippi licensed (licensure eligible), board eligible/certified in Pediatrics, Internal Medicine or Family Practice and should expect to maintain a part-time medical practice at the center. Nice facility, excellent benefits, malpractice paid, paid retirement, good salary. CV's of inquiries should be directed to: Wilbert L. Jones, Executive Director, 2700 6th Street, Meridian, MS 39301 (601) 693-0151 FAX (601) 693-9182.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

Consider becoming a part of EMSA Limited Partnership. In associating with EMSA, you'll be joining a nationwide network of highly skilled, professionally recognized physicians.

Various EM opportunities are available statewide. **Administrative opportunity available in Natchez.** Outstanding employee package including malpractice insurance, health/life/disability for FT positions, CME, and a 401 (K) Plan. Please call or write to:

Carrie Rubin
EMSA Limited Partnership
100 N. W. 70 Avenue
Ft. Lauderdale, FL 33317
1-800-443-3672, Ext. 265
(305) 792-3531 FAX

MEA

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Excellent Opportunity for Board-Certified or Board Prepared Emergency Physician with interest in teaching residents to join stable, all Board-Certified group. Recently approved Emergency Medicine Residency. Community emergency department with 36,000 visits per year. Excellent first year compensation as independent contractor with early partnership potential. Flexible scheduling with extended double coverage. **Reply to Sarah B. d'Autremont, M.D., FACEP or Marie Wegeman, Baton Rouge General Medical Center, P.O. Box 2511, Baton Rouge, La., 70821. (504) 387-7053.**

IMMEDIATE OPENINGfor BC/BE primary care physicians in progressive multi-specialty clinic in quiet southeastern Mississippi town. 35,000 PSA with $150,000.00 potential income and 2 year income guarantee. Strategic location provides convenience of 3 large cities and is only 40 minutes from a major university and medical center. Serious Inquiries: Paul Gardner, CPA, PO Box 607, Lucedale, MS 39452, (601) 947-3161.

ED PHYSICIANS: Excellent opportunity for **Career-Oriented** Emergency Physicians, to work as an independent contractor. Positions available in the following Alabama locations: Birmingham, Cullman, Ft. Payne, Gadsden, North Shelby County, and Talladaga. Experienced Physicians, BC/BE in Emergency Medicine or Primary Care are preferred. Professional Liability Insurance procured on Physicians behalf, and tail coverage provided by company. For additional information, please contact Lois J. North, **SOUTHERN MEDICAL GROUP, INC.**, at (205) 322-9497, or forward current CV to: 2100-A SouthBridge Parkway, Suite 490, Birmingham, AL 35209.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

BC/BE (preferably) physicians in Family Practice, Internal Medicine, Emergency Medicine, or Surgery needed for several full time positions in Brookhaven,Grenada, Oxford, Vicksburg, and Yazoo City, MS. Professional liability and benefits (health, life, and disability insurance) provided. The salary range is between $120,000 to $130,000 per year. ACLS is required.

We also have several float positions available with a salary range between $90,000 to $120,000 per year.

PRI-MED, Inc. is a Memphis based corporation with client hospitals in Mississippi, Tennessee and Arkansas. If you would like additional information please send you curriculum vitae to Susan Maxey or call 800-821-6382 (outside TN) or 800-821-7522 (TN) or call collect (901) 685-9305.

PRI-MED, Inc.
6263 Popular Ave. #700
Memphis, TN 38119

Tired of Night Call and Administrative Burdens?

An incredible practice is now available within a progressive, established group of Family and Industrial Medicine Physicians. No hospital call. *Ownership Opportunities* in this expanding Episodic Care and Industrial Medicine Clinic system. Potential income of $150,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Have a busy practice from day one, with extremely high, long-term income potential.

Please send your CV to:
PO Box 13849, Jackson, MS 39236-3849
or contact Sheila M. Harkins, (800) 844-6503
Mississippi Emergency Association, PA

MONTANA and IDAHO - Primary care physicians needed in rural communities, where you will make the difference. Guaranteed salary and wonderful benefits packages. No crime, drug, or traffic problems in these communities. Recreation of all types at your back door. For detailed information Call or send CV to: FHS, 4656 So. Utah Ave, Butte, MT. 59701. Ph: 406-494-1448.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

RADIOLOGY AT WOMAN'S HOSPITAL, Baton Rouge, Louisiana. For the diagnostic radiologist interested in ultrasound, mammography, and CT, along with general radiology, in an expanding, highly respected Ob-Gyn specialty hospital. Construction is underway on completely new Radiology Department and Breast Center. Pleasant work environment, highly trained staff, excellent compensation, and very generous time off. Baton Rouge is a nice place to live, and is a short drive to New Orleans and the Gulf Coast. **Call or write: Chet Coles, MD or James Ruiz, MD**, PO Box 95009, Baton Rouge, LA 70895, 504-924-8266, FAX: 504-924-8242.

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

Classified

Abbot Laboratories **VISION** Blood Analyzer. Runs 37 different patient specimens, complete with instruction tapes, manuals, and specimen tubes. Take up the notes. (601) 833-4212 or (601) 833-1946.

MIDMARK SURGERY TABLE - MODEL III, $3,000.00 IN EXCELLENT CONDITION - CALL 601/268-5240.

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Medical Office Space Available for Lease
Ridgeland, Mississippi

Office space consists of 25 X 40 feet, or 1,000 square feet, available August 15, 1992, located in shopping center on Lake Harbour Drive at Highway 51. Space includes waiting room and receptionist area, private office with rest room, laboratory, 3 examination rooms and patient's rest room. Call 859-5251.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

Items for the Placement Service or Classified Section should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

Index to Advertisers

Cambridge Equity Advisors 266
CancerPay Plus 255

Deposit Guaranty Investments 252
Disability Determination 271
Doctors Insurance Reciprocal 269

Eli Lilly & Co. - Humulin **6**
Employer Plus, Inc. 264

Harreld Chevrolet-Oldsmobile 251

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 267
MS Emergency Association ..... 271,272 & 273
MS Methodist Rehabilitation Center.. **second cover**
MS Physicians Insurance Company **4**
MSMA Benefit Plan & Trust **8**

Post Graduate Medicine 268
Premier Printing 268
PRI-MED, Inc. 273

Rehabilitation Institute of New Orleans 268

G. D. Searle & Co. - Calan ..... **fourth cover**

The Doctors' Company 248
Trustmark 259

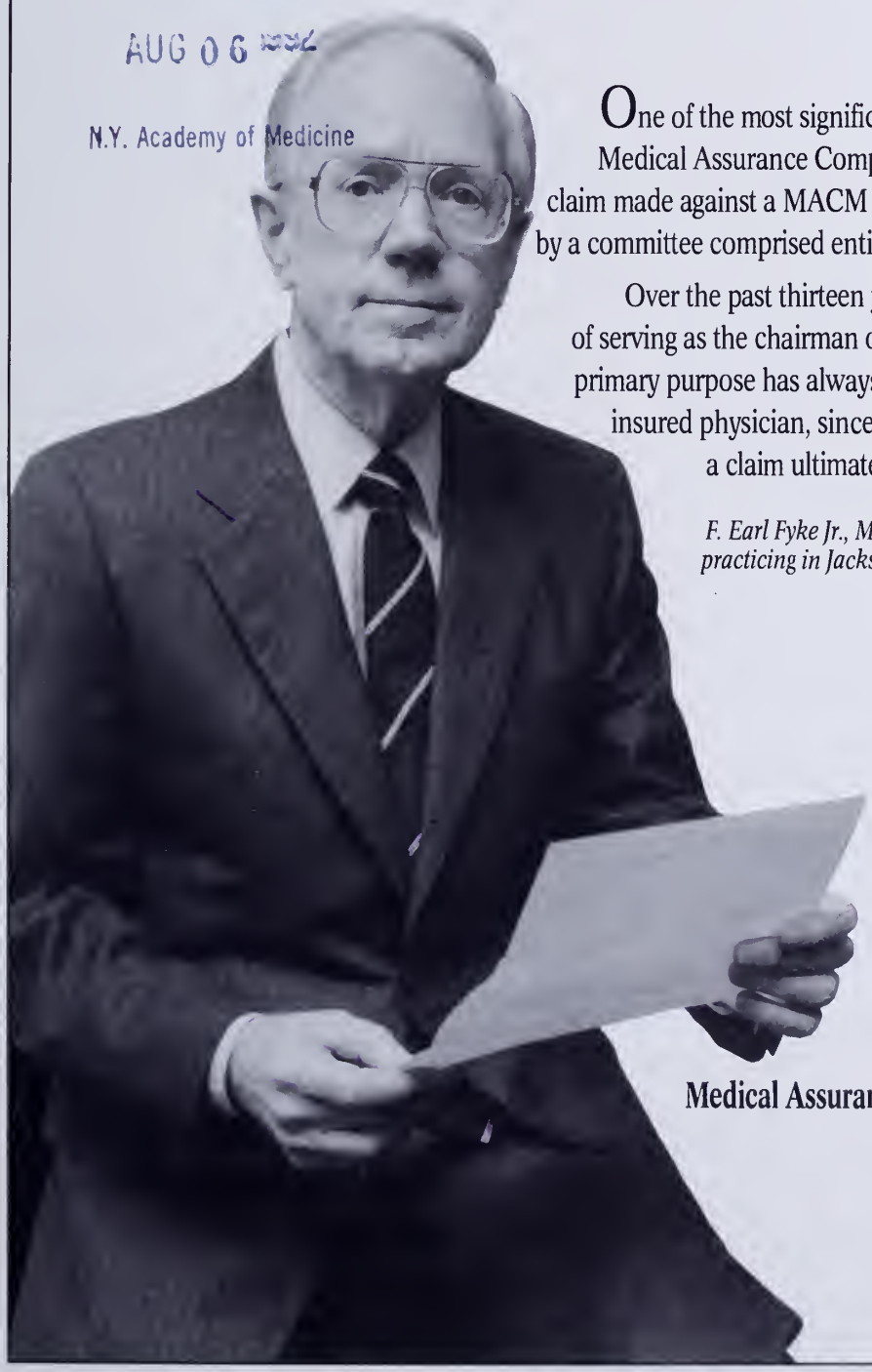
US Air Force 265
US Army Active 254
US Army Reserve 258

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.

LIBRARY

AUG 06

N.Y. Academy of Medicine



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi

1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

For the many faces of mild hypertension

#1 MILD



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION[1]*

- Effective 24-hour control[2]
- Single-agent efficacy
- Well tolerated†
- No adverse effects on total cholesterol, plasma glucose levels, renal function,‡ or serum electrolytes[3-6]

ONCE-DAILY

Calan® SR

verapamil HCl

180 mg

SUSTAINED-RELEASE CAPLETS 240 mg

For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:102S-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

© 1992 Searle

A92CA6694T

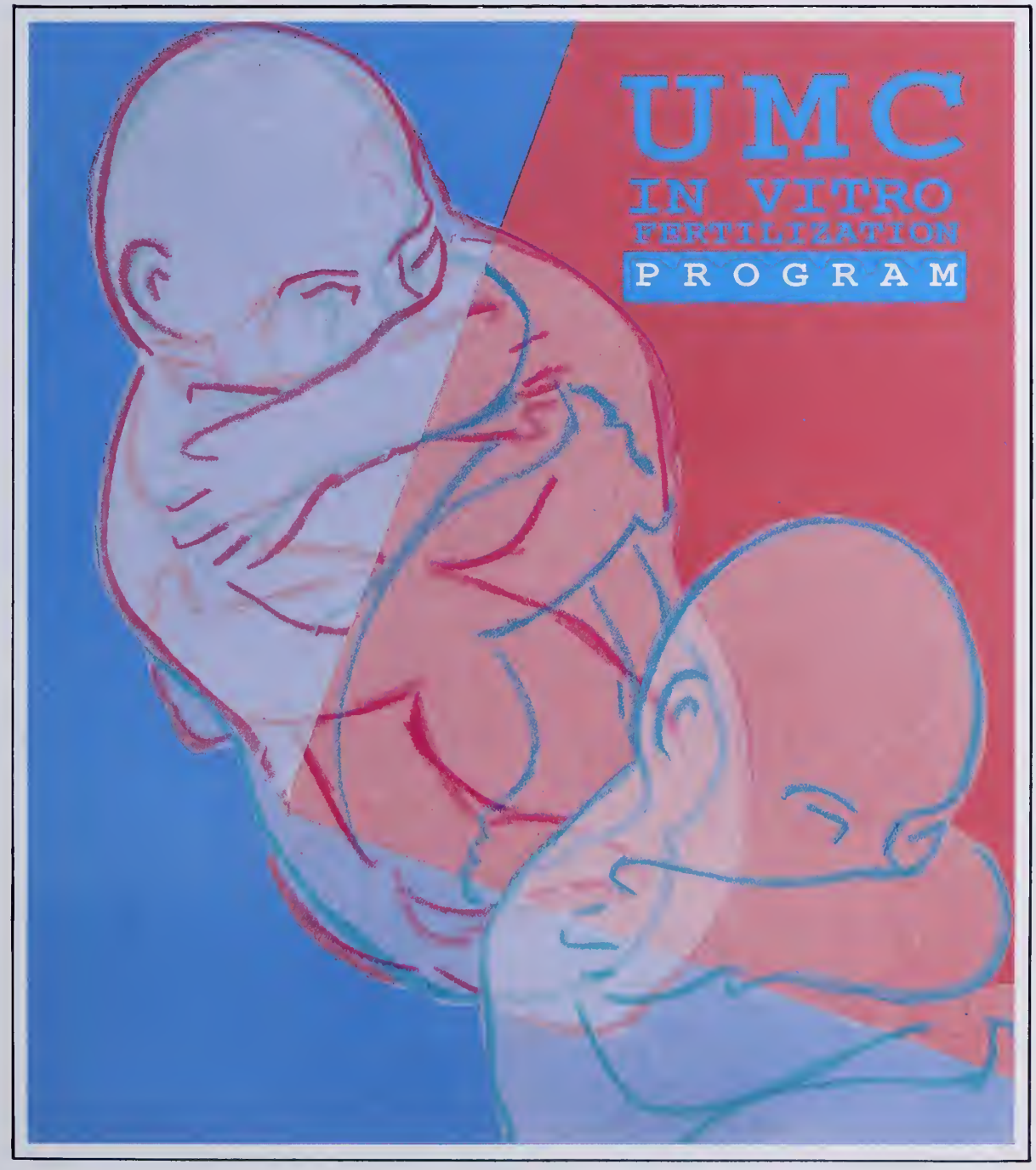
SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

JOURNAL

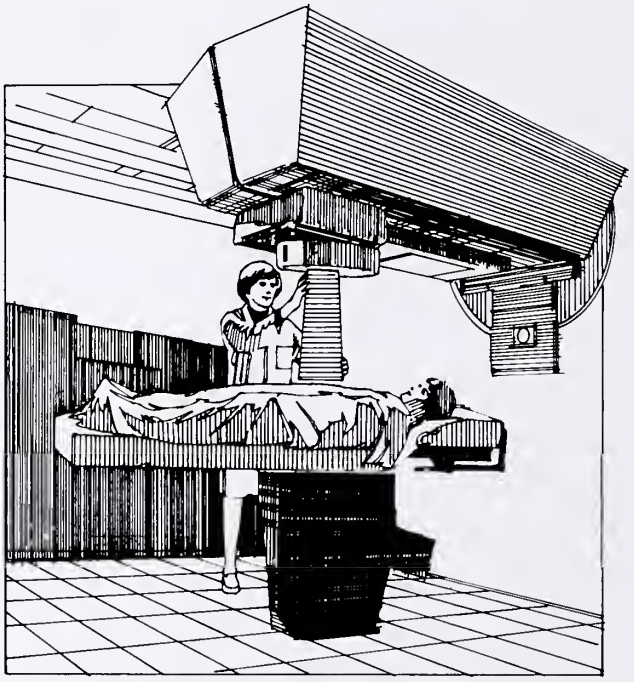
OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

AUGUST 1992



Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

AUGUST 1992 VOLUME XXXIII NUMBER 8

SCIENTIFIC ARTICLES

The University of Mississippi Medical Center In Vitro Fertilization Program: 1984-1991 275
Victoria M. Sopelak, PhD; Cecil A. Long, MD; Mark L. Jutras, MD and Bryan D. Cowan, MD

Relationship of Anterior Cruciate Ligament Injury To Notch Width Index (A Roentgenographic Study) 279
Gene R. Barrett, MD; Jean Marie Rose, RN and Elaine Marie Reid

SPECIAL ARTICLE

Medicaid Income Can Be Tax-Deferred 285

EDITORIALs

"The man with an eagle in his breast ..." 286
William C. Gates, MD

"Contact Your Doctor For A Prescription" 287
Joseph E. Johnston, MD

DEPARTMENTS

Letters 288
Current Opinons 289
Medical Organization 292
From the University of Mississippi Medical Center 298
New Members 301
Deaths 303
Personals 306
Placement Service 309

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
A. Jerald Jackson, MD
and the editors

THE ASSOCIATION
William C. Gates, MD
President
Don Q. Mitchell, MD
President-Elect
D. Stanley Hartness, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6393) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 8

August 1992

Dear Doctor:

The Agency for Health Care Policy and Research (AHCPR), US Public Health Service, has recently published three clinical practice guidelines, including information of proven clinical value relating to ***Acute Pain Management*; *Urinary Incontinence in Adults*; and *Prediction, Prevention, and Early Intervention of Pressure Ulcers*.**

These guidelines are the first in a series of such documents which cover a wide variety of medical topics. They are designed to give physicians the benefit of scientifically-validated information which can positively affect patient outcomes.

Some highlights: Standard practice for pain control may fail to relieve pain in about half of post-operative patients; unrelieved pain or trauma can delay recovery; when pain is controlled, patients tend to be discharged from hospitals earlier and may have fewer chronic problems such as phantom limb pain after amputations. Most cases of urinary incontinence can be significantly improved or cured -- yet half of those affected never seek medical help. Most pressure ulcers can be prevented with careful attention to patient risk factors.

Guidelines are developed by private panels of recognized experts representing a broad spectrum of physicians/specialties and other health care professionals; panels also include representation by patients/consumers. A total of 16 topics have been identified for guideline development, including: low back problems; diagnosis and treatment of benign prostatic hyperplasia; evaluation and early intervention in HIV positive asymptomatic patients; otitis media in children; diagnosis of depressed outpatients in primary care settings; comprehensive care in sickle cell disease; post-stroke rehabilitation; and development of quality determinants in mammography. Other topics are being considered and will be added to the list.

Guidelines are published in three formats including a clinicians' version; a quick-reference guide for health professionals; and a patient/consumer pamphlet (also available in Spanish) suitable for distribution by hospitals or in physicians' waiting rooms.

All guidelines, including the quick-reference guide and patient education materials, are available without charge from: AHCPR Publications Clearinghouse, PO Box 8547, Silver Springs, MD 20907, or call: 1-800-358-9295.

MARK YOUR CALENDAR !!

The MSMA 125th Annual Session will be held
April 28 - May 2, 1993
at the Royal d'Iberville Hotel, Biloxi, Mississippi



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

A Risk Retention Group

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 8

AIDS Growth Is Disturbing

Jackson, MS - The Southeast reported the largest number of new AIDS cases in 1991 and the largest increase in cases from 1990, according the Centers for Disease Control in Atlanta.

Mississippi was among those cited, with most new cases in the Mississippi Delta. AIDS killed 60 Mississippians in 1991 and known deaths from the disease in the state numbered 570 through May, Mississippi Department of Health records show.

Although the bulk of Mississippi's AIDS cases came through homosexual or bisexual activity, the number of victims through heterosexual acts went from 12 cases last year to 55 cases through May 1992, health officials say.

TB Outbreaks

Meridian, MS - East central Mississippi has one of the highest tuberculosis rates in the state, with the overcrowded lauderdale County jail and the Choctaw Indian reservation the sources of many cases, officials said.

About 5 percent of Mississippians have the sometimes-fatal lung disease, with a high number of cases consistently found in District VI in east central Mississippi, Health Department statistics show.

Neshoba and Lauderdale counties in particular have high rates. In 1990, Neshoba County's TB rate was 56.5 cases per 100,000 people - almost double any other county's rate.

Lauderdale County's rate of 23.8 cases also was one of the highest in the state that year - more than double the U.S. rate.

Currently, the Lauderdale County jail is free of known TB cases.

Spinal Cord Injury

Jackson, MS - According to the National Spinal Cord Injury Research Data Center, one of every 10 serious spinal cord injuries in the United States each year relates to diving.

Nine Mississippians have suffered serious spinal cord injuries from diving so far this year. At the present rate, estimates put more than 17 Mississippians at risk of serious spinal cord injuries from diving before the end of 1992.

The typical victim of a diving injury is a young male between the ages of 13 and 33; more than 50 percent of victims consumed alcohol before their diving injury occurred.

The Mississippi State Department of Health is working with the Department of Rehabilitation Services on a disability prevention project to reduce the incidence of disabilities in Mississippi. Tracking and investigating disabling conditions -- such as spinal cord injuries -- will allow the agencies to plan strategies to prevent future injuries.

THE UNITED STATES ARMY RESERVE
HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM
$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

The University of Mississippi Medical Center In Vitro Fertilization Program: 1984-1991

VICTORIA M. SOPELAK, PhD
CECIL A. LONG, MD
MARK L. JUTRAS, MD
BRYAN D. COWAN, MD

Achieving a pregnancy through in vitro fertilization (IVF) treatment depends on many factors including the cause of infertility, responses to the ovulation induction medications, and the number of attempted IVF cycles. Since its inception in 1984, the IVF program at the University of Mississippi Medical Center (UMC) has updated technology, personnel, and facilities. This article reviews the UMC IVF program statistics and updates the initial report of our first IVF pregnancy.

MATERIALS and METHODS

From 1984 to September, 1991, 270 patients had IVF treatment at UMC to overcome their infertility. In 43.7% of these patients, fallopian tube disease (118 patients) was the primary etiology of infertility. Other infertility diagnoses included: endometriosis, unexplained infertility, male factors, combined factors and other causes such as ovulatory disorders and hostile cervical mucous (Table 1). These 270 patients had 565 cycles stimulated with follicle-developing drugs and 448 oocyte recoveries were performed (Table 2). Oocytes were successfully fertilized and an average of 3.4 growing embryos were transferred in 352 cycles. IVF treatment of this group of patients has resulted in 67 pregnancies.

Development of multiple egg-containing follicles is most frequently accomplished by injections of human menopausal gonadotropins (hMG). The two preparations available for clinical use are Pergonal (composed of luteinizing hormone (LH) and follicle stimulating hormone (FSH) in a 1:1 ratio; Serono Lab., Norwell, MA) and Metrodin (FSH only; Serono Lab.). The UMC

Table 1 - Success of IVF Based on Infertility Diagnosis

Diagnosis	Number of Patients	Percentage of Patients	Number Pregnant	% Pregnant by Diagnosis
Unexplained	20	7.4%	8	40.0%
Tubal Disease	118	43.7%	33	28.0%
Endometriosis	44	16.3%	9	20.4%
Male Factor	11	4.1%	1	9.1%
Combined	47	17.4%	10	21.3%
Other	30	11.1%	6	20.0%
Patient Total	270		67	

Table 2 - UMC-IVF Statistics (1984-1991)

Number of Patients	270
Number of IVF Cycles Started	565
Number of Oocyte Recoveries	448
Number of Follicles Aspirated	4293
Number of Eggs Obtained	2945
Number of Eggs Inseminated	2476
Number of Eggs Fertilized	1510
Number of Embryos Transferred	1207
Number of Cycles with Transfers	352
Number of Pregnancies	67
Average Number of Eggs per Recovery	6.57
Average Number of Embryos Transferred	3.43
Pregnancy Rate per Patient	24.8%
Pregnancy Rate per Egg Recovery	14.9%
Pregnancy Rate per Embryo Transfer	19.0%

program has used several protocols for follicular stimulation. All but one utilize hMG.

Our current protocols are designated S2, R2, NP and CC. S2 achieves follicular stimulation with clomiphene citrate (50 mg on cycle days 2 to 6) and hMG (150 IU) beginning on cycle day 3. Phlebotomy for measurement of circulating levels of estradiol (E_2) by radioimmunoassay begins on cycle day 7. Ultrasound monitoring begins when the circulating E_2 levels are above 500 pg/mL. Human chorionic gonadotropin (hCG) (Profasi, 10,000 IU; Serono Laboratories, Randolph, MA) is administered when 3 or more follicles are greater than 15mm and the circulating E_2 concentration is above 200 pg/follicle. Follicular aspiration is then carried out 34 hours after hCG administration. An unwanted event associated with this protocol is a spontaneous LH surge. This results in cancellation of the cycle since it is impossible to accurately schedule an optimal time for follicle aspiration. To avoid these unwanted LH surges, our R2 regimen utilizes a gonadotropin stimulating hormone-agonist (250 ug) (Lupron; TAP Pharmaceuticals, North Chicago, IL) concurrent with 150 IU hMG beginning on cycle day 2. The same follicle monitoring criteria are utilized. Individualized or non-protocol treatment (frequently utilizing higher concentrations of hMG) are grouped together under the NP category. Finally, some women produce only a few follicles in response to any hMG protocol. To reduce the cost of repeated hMG treatment cycles in these individuals, we have developed a clomiphene citrate only protocol (CC). Table 3 summarizes the distribution of patients by protocol and the number of pregnancies occurring with each regimen.

Initially, from 1984 to 1987, oocytes were recovered from a woman's ovaries in a hospital operating room using general anesthesia and laparoscopy. Since then, follicular aspiration has been done in an office setting (UMC Pavilion) using mild sedation and ultrasound-guided needle aspiration to recover the oocytes. Sedation is produced with intermittent intravenous boluses of fentanyl and midazolam. A local block of lidocaine is placed in the vagina at the expected sites of needle entry. Oocyte aspiration is accomplished with a 17 gauge echogenic needle that is easily detected by sonography. The 20-25 minute procedure is well tolerated by the patients.

Table 3 - Follicular Stimulation Protocols Used for IVF

Protocol	Number of Cycles	Number of Pregnancies
CC	26	1
R2	244	32
S2	92	13
NP	203	21

RESULTS

When we evaluated attainment of pregnancy compared to infertility diagnosis in our program, we found that 40% of patients with unexplained infertility, 28% of patients with tubal disease, 20.4% of women with endometriosis, and 9.1% of patients with male factor became pregnant (Table 1). Patients with combined factors or other causes for their infertility attained a 20 - 21.3% pregnancy rate.

Table 4 categorizes the cycles based on the number of attempts by our patient population. The individual per cycle pregnancy rate for women receiving embryos ranged from 13% to 27.3%. While these results suggest that individual cycle differences existed, these rates are not statistically different from one another ($x^2 = 2.6$). However, the number of IVF cycles attempted influenced the chances for pregnancy. The cumulative pregnancy rate (life table analysis) for our population of patients that attempted up to 5 cycles was 69% (Table 4 and Figure 1). Thus, the overall cumulative chances for success increase when couples are able to attempt IVF more than once, even though the chance of pregnancy per cycle remains constant.

Pregnancy does not always result in delivery of a live offspring (Table 5). Of the 67 pregnancies achieved through September, 1991, 9 have ended in a spontaneous miscarriage, 5 were ectopic (tubal) pregnancies and 3 terminated as fetal demise (at 19, 22, and 23 weeks

Table 4 - Individual Cycle and Cumulative (Life Table Analysis) IVF Pregnancy Success for UMC Patients Attempting 5 Cycles

Cycle Number	Treatment Start (Patients)	Receiving Embryos at Transfer	Number Pregnant	% Pregnant per transfer	Percentage Cumulative Pregnant/Transfer
1	270	163	30	18.4	18.4
2	141	91	18	19.8	34.5
3	64	40	10	25.0	50.9
4	35	23	3	13.0	57.3
5	19	11	3	27.3	69.0

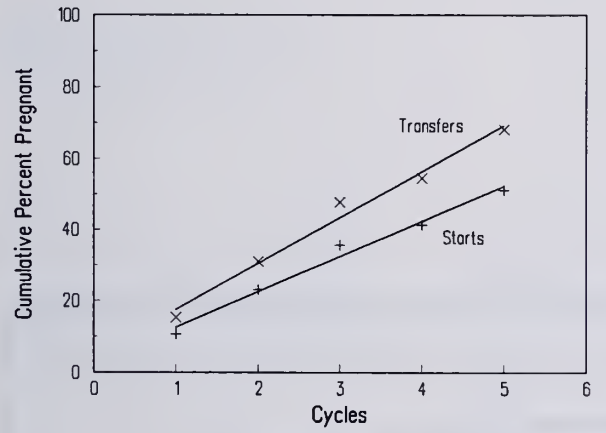


Figure 1. *Cumulative pregnancy rates (life table analysis) for UMC-IVF patients who attempted up to 5 IVF cycles. Data show the chance for success with multiple IVF attempts as a function of stimulation cycle starts or embryo transfers.*

Table 5 - Outcome of UMC-IVF Pregnancies

	Pregnancies	Children
Delivered		
Singleton	31	31
Twins	10	20
Triplets	0	-
Ongoing		
Singleton	7	(7)
Twins	1	(2)
Triplets	1	(3)
Losses		
Abortion	9	-
Ectopic	5	-
Demise	3	-

gestation). Forty-one patients delivered 51 children from 31 singleton and 10 twin pregnancies resulting in 29 girls and 22 boys. Nine patients have ongoing pregnancies, one of which is pending triplets.

CONCLUSION

In summary, we find that the highest pregnancy rates are expected in couples where no known cause of infertility can be found. Couples where the oocytes cannot reach the uterus because of anatomical obstruction (tubal or peritoneal disease) also performed well. Our poor results with couples experiencing infertility due to a male factor is consistent with the overall experience of other IVF programs in the United States.[1-4] Pregnancy success is influenced by the number of IVF cycles attempted and the number of successful embryo transfers. Although the risk of an ectopic (tubal) pregnancy is increased in IVF pregnancies compared to pregnancies conceived naturally, the risk of abortion or of an abnormal offspring after conception through IVF is not higher than the normal population. IVF is now considered a standard medical procedure for infertility unfortunately, many insurance companies do not provide coverage for this important treatment option. Thus, many couples are not financially able to follow our "recipe for success" and attempt IVF several times. ❑

2500 North State Street
Jackson, MS 39216-4505

REFERENCES

1. Medical Research International, The American Fertility Society Special Interest Group: In vitro fertilization/embryo transfer in the United States: 1985 and 1986 results from the National IVF-ET Registry. *Fertile Steril* 1988;49:212-215.
2. Medical Research International, The American Fertility Society Special Interest Group: In vitro fertilization/em-

bryo transfer in the United States: 1987 results from the National IVF-ET Registry. *Fertile Steril* 1989;51:13-19.
3. Medical Research International, The American Fertility Society Special Interest Group: In vitro fertilization/embryo transfer in the United States: 1988 results from the National IVF-ET Registry. *Fertile Steril* 1990;53:13-20.
4. Medical Research International, The American Fertility Society Special Interest Group: In vitro fertilization/embryo transfer in the United States: 1989 results from the National IVF-ET Registry. *Fertile Steril* 1991;55:14-23.

***Dr. Sopelak** is associate professor of obstetrics and gynecology, **Dr. Long** is assistant professor of obstetrics and gynecology, **Dr. Jutras** is assistant professor of obstetrics and gynecology, and **Dr. Cowan** is professor of obstetrics and gynecology all from the Department of Obstetrics and Gynecology, University of Mississippi Medical Center*



Relationship of Anterior Cruciate Ligament Injury To Notch Width Index (A Roentgenographic Study)

GENE R. BARRETT, MD
JEAN MARIE ROSE, RN
ELAINE MARIE RIED

Anterior Cruciate Ligament (ACL) injury of the knee is the most common and disabling injury in sports. This ligament rests in the intercondylar notch of the femur (knee). One theory for the cause of rupture of the ACL is a "stenotic" or "narrow notch". A hyperextension mechanism of injury to a knee causes the ACL to hit the roof of the notch and cause rupture. Therefore, a notch that is narrow compared to the width of the femur should increase the risk of ACL rupture. In an effort to determine the relationship of the notch width index (notch width/femur width) a study was undertaken to compare the normal population to knees with ACL deficiency or tears.

LITERATURE REVIEW

A deleterious correlation between the ACL and the intercondylar notch was originally suggested in 1938 by Palmer.[1] Keiffer found that although anterior outlet stenosis was common in those knees with ACL tears, a narrow posterior arch predisposed one to such an injury.[2] Also, Houseworth backed up the role of a narrow posterior arch in ACL injury with the aid of a study using radiographic views of the notch and computer graphics in which he compared 50 normal knees to 50 knees with acute ACL tears.[3] He noted that the posterior arch is the narrowest aspect of the notch. Figure I demonstrates the anatomical aspects of the intercondylar notch of the femur.

Norwood and Cross in their study of cadaver knees support the belief that the ACL impinges on the anterior notch in full extension and with further hyperextension tears result.[4] Feagin agreed that a narrowed notch has been observed with acute ACL disruptions, but also states that narrowing of the intercondylar notch can occur secondary to chronic knee instability or after a failed ACL repair or reconstruction.[5] Osteophyte proliferation and notch encroachment are common in the chronically unstable knee.[6] This formation is an



Figure I- Anatomical aspects of the intercondylar notch of the femur, anterior and posterior outlet.

attempt at repair which begins as granulation tissue and matures into fibrocartilage. Eventually a mass of bone covers the fibrocartilage and accumulates about the joint margin. In time the osteophyte greatly alters the congruency of the joint.[7] Souryal studied bilateral ACL injuries and defined intercondylar notch stenosis as "critical" when the NWI measures less than .2000.[8] The notch width index is the ratio of the width of the intercondylar notch to the width of the distal femur at the level of the popliteal groove (Souryal, 450) (see Figures 2 A&B). For the purpose of this study a "narrowed notch" will be defined as less than .2000. We agree that this measure is an indication for the use of preventive action against a possible ACL tear in the future or the need for an adequate notchplasty at the time of surgery. Notchplasty is presently used in ACL reconstruction to widen and heighten the notch so as to avoid impingement of the notch on the graft (patella tendon, allograft, etc.). Souryal found no statistical difference between the NWI in normal and acute ACL injury. However, when comparing a bilateral ACL injured group to the normal and acute ACL groups there was a significant difference.[8]

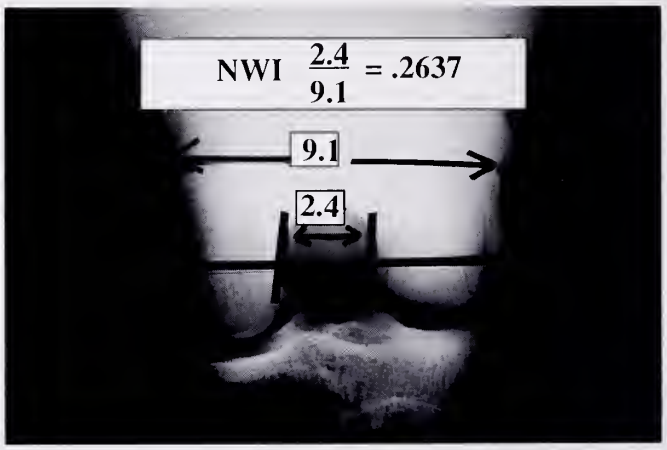


Figure 2 A - Souryal's formula used to determine notch width index (the narrowest width of the notch/width of the femur at the level of the popliteal groove).

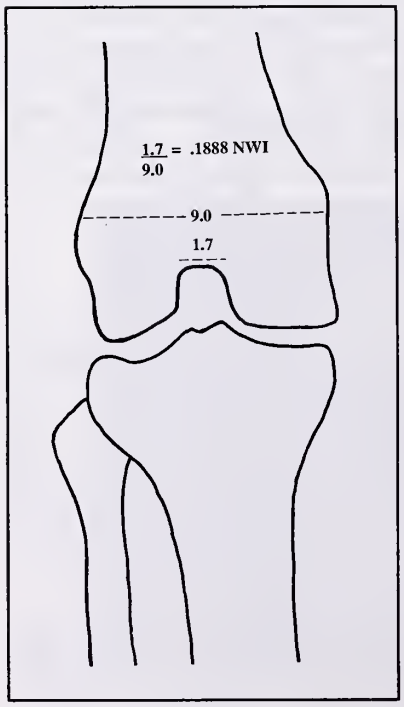


Figure 2B

Anderson noted that a relationship may exist between the shape of the intercondylar notch and the incidence of ACL tears. Upon making tracings from distal CT scans he identified 5 shapes associated with the notch opening. These shapes were numbered 1-5 with number one being an inverted U to five which is a cresting wave with a flattened superior medial corner. He found the "wave shaped" notches to be unusual in the normal knee and quite possibly another indication for notchplasty.[9] Souryal, believed that young individuals who sustain an ACL tear by non-contact mechanisms and have a low NWI, carry a significant risk for a contralateral ACL injury. Therefore, they should be counseled regarding that possibility in hopes of avoiding it.[8]

MATERIALS AND METHODS

During the period from 2/91 to 9/91 tunnel view radiographs were taken on 56 patients who were preoperatively diagnosed with ACL tears. We will refer to them as Group I. They were to undergo surgery for reconstruction. The notch width index was measured in accordance with Souryal's formula (ratio of the width of the notch to the width of the distal femur). These 56 patients consisted of 36 males and 20 females whose ages ranged from 14-46 years with an average age of 28 years. Injuries sustained more than six weeks before the initial examination were classified as chronic, whereas patients whose initial exam was within 2-6 weeks of injury were considered acute. The mechanism of injury along with the nature of the injury, contact/non-contact, was also determined.

The five different shapes devised by Souryal (see Figures 3 A - E) were used to further categorize Group I. The comparison group



Figure 3 A - Souryal's shape #1



Figure 3 B- Souryal's shape #2



Figure 3D - Souryal's shape #4



Figure 3E- Souryal's shape #5



Figure 3C - Souryal's shape #3

consisted of 212 patients who over the same time period were diagnosed with injuries other than ACL tears. This will be referred to as Group II. Notch view radiographs were taken of Group II and the NWI was calculated. Group II was also classified according to the same shapes as those with ACL tears.

Notch width indexes were averaged for Group's I and II as a whole as well as the average for males and females.

RESULTS

Analysis of the 56 patients which compromised Group I, those with ACL deficient knees, revealed an overall NWI of .1918 as compared to Group II, normal population, whose overall NWI was .2114. The 36 males in Group I had a NWI averaging .1886, while the 136 males in Group II had a NWI averaging .2129. The 20 females in Group I had a NWI averaging .1975, while the 76 females in Group II had a NWI averaging .2087.

From Group I, six subgroups were named for the mechanism of injury (see Figure 4). Their names and NWI averages are as follows:

Hyperextension	57.14%	.1932
Twisting	23.12%	.1878
MVA	7.14%	.1820
Falling	5.36%	.1860
Running	5.36%	.2032
Tackling	1.79%	.2195

Of these mechanisms of injury 41 were non-contact in nature and 15 were contact in nature. Seventy-eight percent (25 of the 32) of the injuries in hyperextension were of a non-contact nature and all those suffering from twisting injuries were also non-contact in nature. With both of these mechanisms a narrowed notch was observed.

Finally, Group I and Group II were categorized into shapes. Of these shapes #5, which is in the form of a cresting wave, occurred 12.5% of the time in Group I while only occurring 2.36% of the time in Group II. However, in Group II the most commonly seen shape was #1 which happened 39.62% of the time while

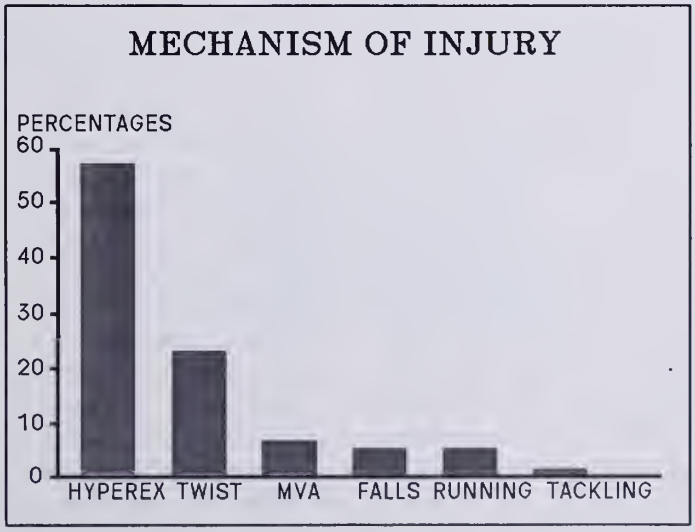


Figure 4

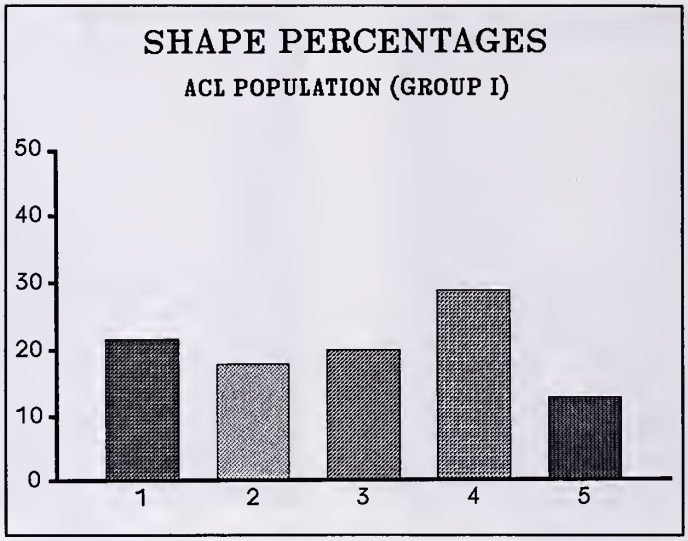


Figure 5

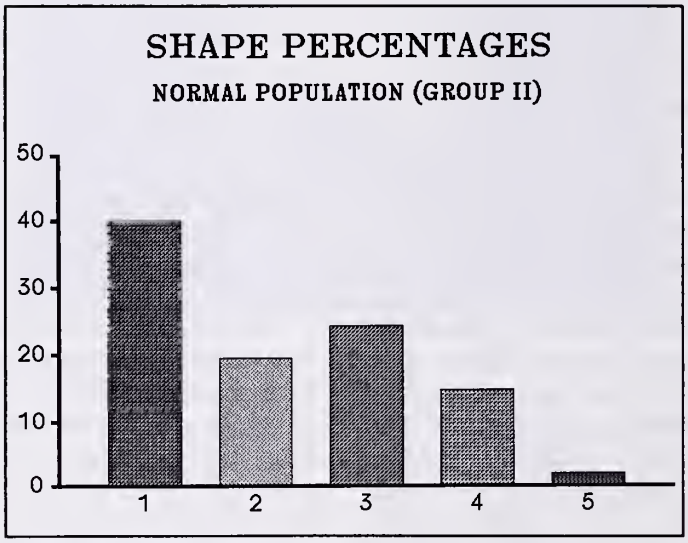


Figure 6

occurring only 21.43% of the time in Group I (see Figures 5 & 6). The average NWI of shape #1 in Group II is .2459, well above the total NWI average for both groups.

DISCUSSION

The intercondylar fossa is a deep notch that is between the medial and lateral condyles of the femur posteriorly. The walls of the notch are rough and concave. The anterior cruciate ligament of the knee joint is attached to an impression on the proximal and posterior part of its lateral wall.[10]

The overall NWI of knees with ACL tears is smaller compared to the NWI of the general population. This finding is analogous to the results shown by the other researchers mentioned in this article. Our data also implies that the anterior outlet of the notch is liable for the tears that occur in those with narrowed notches (.1932 average of those with hyperextension injuries). During hyperextension a stress is put on the ACL when it comes in contact with the anterior notch (57.14% of our injuries were due to hyperextension). We feel that for preventive reasons it is also important to determine the shape of the notch, as our data clearly demonstrates that the ACL deficient knee tends more toward shapes #4 and #5 while the normal population usually has a shape nearer to that of shape #1 (Figures 3, 5 & 6). Therefore, the shape and width of the person's notch could be used as another screening tool to warn against future tears. A stenotic arch seen on x-ray or at the time of surgery in a diagnosed ACL deficient knee provides rationale for the notchplasty. Finally, this study suggests that a narrowed intercondylar notch is the basis by which we can determine one's predisposition to ACL deficiency.

CONCLUSION

1. A non-contact hyperextension injury places a knee with a narrowed notch at greater risk of an ACL tear.
2. The anterior arch of the intercondylar notch is the area of the notch which proves to have a pathological relationship to ACL injury.
3. The specific shape of the intercondylar notch is a factor in determining one's predisposition to an ACL tear. Shapes #4 and #5 are more prone to ACL tears.
4. A stenotic arch is an indication for notchplasty. (Widening the intercondylar notch during ACL reconstruction.)
5. A narrowed notch provides rationale for counseling a patient about the probability of an initial or contralateral ACL tear. ❑

1325 East Fortification Street
Jackson, MS 39202

REFERENCES

1. Palmer I. On the injuries to the ligament of the knee joints. A clinical study. *Acta Chir Scand* (*Suppl* 53), 1938.
2. Keiffer DA, Curnow RJ, Southwell RB, et al. Anterior cruciate ligament arthroplasty. *Am J Sports Med* 12;1984:301-312.
3. Houseworth SW, Mauro VJ, Mellon BA, Keiffer DA. The inter-

condylar notch in acute tears of the anterior cruciate ligament: a computer graphics study. *Am J Sports Med* 15;1987:221-224.
4. Norwood LA, Cross MJ. The intercondylar shelf in the anterior cruciate ligament. *Am J Sports Med* 5;1977:171-176.
5. Feagin JA, Cabaud HE, Curl WW. The anterior cruciate ligament: radiographic and clinical signs of successful and unsuccessful repairs. *Clin Orthop* 164;1982:54-58.
6. Jackson, DW, Drez D, Jr. The anterior cruciate deficient knee: new concepts in ligament repair. St. Louis, CV Mosby CO., 1987, p 275.
7. Enneking, EF. Clinical musculoskeletal pathology. Gainesville: Storter Printing Co., 1977, p 335.
8. Souryal TO, Moore HA, Evans JP. Bilaterality in anterior cruciate ligament injuries: associated intercondylar notch stenosis. *Am J Sports Med* 16;1988:449-454.
9. Anderson AF, Lipscomb, AB, Liudahl DJ, Addlestone RB. Analysis of the intercondylar notch by computed tomography. *Am J Sports Med* 15;1987:547-552.
10. Gray H. Anatomy of the body. Philadelphia: Lea & Febiger, 1974, p 243.

***Dr. Barrett** is an orthopaedic surgeon practicing in Jackson, MS; Jean Marie Rose is a registered nurse and Elaine Ried is a research assistant working with Dr. Barrett.*

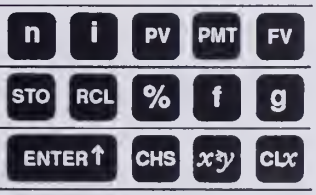
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- **No-Load Mutual Funds/Other Securities**
- **23 Years Experience**
- **Tested Asset Allocation Model**
- **Fee-Only Advisor**

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings Up To 15 %
✔ 2. Established by Your Association	
✔ 3. Savings over what you currently are paying	
✔ 4. Responsive to your needs	
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association

Medicaid Income Can Be Tax-Deferred

If you are looking for tax-relief, you may want to examine an option provided by the Mississippi Medicaid Program. Individual physicians receiving Medicaid income from the State of Mississippi can tax-defer up to 25% of their Medicaid payments through the Mississippi Deferred Compensation Plan (MDCP). The maximum deferral through MDCP is $7500 annually.

The Plan permits you to participate as an individual physician working on a contract basis with the State Medicaid Program. If you receive Medicaid payments in your name from the State of Mississippi, you may elect to take a portion of your current income from Medicaid payments and ....

- remove it from today's high Federal and State income tax brackets,
- allow it the opportunity to grow (tax-sheltered) on your behalf, and
- save it for retirement when you may be in a lower Federal and State income tax bracket.

A wide variety of choices are available for investment of the Medicaid payments deferred. Nine funds with five quality companies are offered through MDCP. These funds include stock funds with T. Rowe Price, Fayez Sarofim, and Aetna Life and Annuity Company; two bond funds with Wells Fargo; a money market fund with Aetna; two guaranteed accounts with Aetna, and a guaranteed account with Nationwide.

The MDCP is offered through the Public Employees Retirement System (PERS) of the State of Mississippi. The Plan is authorized under Section 457 of the Internal Revenue Code. The PERS Board has contracted with Systematized Benefits Administrators, Inc. (SBA) to administer and market the Plan. There are no maintenance or transaction fees.

Federal regulations allow that only individuals (with an individual Medicaid number) who perform services for the State may participate in the Plan. Therefore, Medicaid payments received by a partnership or a professional corporation are not eligible for deferment under the Plan.

Participation in other retirement plans may reduce or preclude the amounts you could otherwise contribute to Deferred Compensation. Effective January 1, 1989, reduction for 401(k) and SEP salary deferrals are required. Contributions to IRA/Keogh/HR 10 do not reduce Deferred Compensation (IRC 457) contributions.

If you are eligible, Deferred Compensation is an excellent benefit for Medicaid Providers. If you or your accountant would like more information about the Mississippi Deferred Compensation Plan, Call Jackson 969-2064 or toll free 1-800-846-4551, or write PO Box 105, Jackson, MS 39205-0105. ❑



The President's Page

WILLIAM C. GATES, MD

"The man with an eagle in his breast ..."

Continuing the consideration of factors that serve as the impetus for choosing the practice of medicine as your life's work, I was reminded of a poem that, at least to me, expresses a description of the focus and energy inherent and necessary in a person's desire to complete the task of medical training (and even then it "ain't over" ... it is never "finished" ... "completed" ... "done" ... in the usual sense).

Thirty-seven years ago when I was a freshman in undergraduate school at Vanderbilt, I came across this poem that has haunted me ever since. The poem is untitled and the author is known, but he knew me and my physician colleagues pretty well (or at least he knew something of our internal mental environment -- perhaps he was a physician, too). The poem so piqued my interest that over the years I have kept a copy close at hand ... in fact, as editor of my medical school yearbook, I used the poem on the last page of the book as a final thought for the graduating seniors and as a rally flag for the underclasses. I offer the poem now for your perusal and, I hope, pleasure.

"A man will know when he is chosen
By the Gods to life of quest,
For the restless urge within him
Is an eagle in his breast.

An eagle with frantic pinions
Which may not be caged or tamed,
With eyes on the far horizon
And beckoning stars unnamed.

The goal may be veiled in mystery
And the seeker may have no chart,
But let him turn from his seeking
And the eagle will eat his heart.

Then after the search is over,
After the finding ... rest?
There is no rest for the seeker
With an eagle in his breast."

The author has vividly depicted the mental forces that fuel the search for excellence and the consequences that occur when the urge is not obeyed, as well as the psychic "itch" created by altruism. We as physicians know the task is never truly finished ... brief respites, yes ... true rest, no ... we are compelled to follow the eagle.

I hope my note finds you and yours doing well...

Best regards,
Bill

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 8
AUGUST 1992

"Contact Your Doctor for a Prescription"

Direct patient advertising is the new gimmick for selling some of the over-priced medications that the pharmaceutical manufacturers can't convince the physicians to prescribe in sufficient quantities; or can't get them approved for over-the-counter sales by the FDA. This is usually done over nationwide television during prime-time ... much to most TV viewers chagrin.

Speaking of medications reminds me that the AMA strongly opposes the Prescription Drug Cost Containment Act (Senate Bill 2000) on the basis that it is governmental price control of health care goods and services. That is all well and good considering that we doctors have such rigid pricing controls on our services. I hope they succeed better with drug cost containment than they have with doing something about the controls over our services.

I was recently in Central America and several in our group bought brand name Erythromycin 333 mgm while there at 20 tablets for $10.00. It is ironic that a recently released antibiotic in this county sells for $9.00 per tablet. The pharmaceutical representative assured me that it was "very broad spectrum"; is "very effective"; and though very expensive .... "Just think of how many patients it will keep from having to go to the hospital". This is for the most part an unproven statement, but of course it sounds good, and surely lulls us into accepting just one more Super Bug-killer that may have to be taken off the market in a few months. As far as I'm concerned some of the exotic over-priced medications don't guarantee staying out of the hospital any better than some of the effective less expensive ones.

The bottom line is how many of our patients can pay for these exorbitant priced medications? When I mention this to the pharmaceutical representatives their standard retort is "Well, at least you can prescribe it for your Medicaid patients for it is on the Medicaid formulary". It irks me that the federal government has required us to put all these medications on that formulary where welfare patients can get the medications that my paying patients cannot afford. As difficult as it is for states to come up with the money for welfare programs, it would seem to me that this "Break-the-Bank" formulary program that we have now is a misappropriation of our tax dollars. Alas, we cannot change that federal mandate but we could maybe get the patients to pay a very small percentage of the cost of the medication then, maybe, the patients and the physicians would tend to use effective but more economical medications. With some type of legislative change in these policies there might be enough savings for broader medicaid coverage; more programs for deserving people; and who knows, they might even bring the physician fees up out of the doldrums .... I get 45% of my billed fees now.

The state Medicaid Formulary Advisory Committee and probably the state Drug Utilization Review

(continued on page 288)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(editorial continued from page 287)

Committees are to be abolished and a new broader DUR committee will be formed. Physicians will be offered a greater representation on it than we have had on the other committees mentioned above which have been primarily formed, attended, and run by clinical and practicing pharmacists. This new committee will be supported by the pharmacists, AMA, MSMA, and the federal government. It is up to us to take an active part in this. Without our participation, we may be looking at punitive measures being thrust upon us for things such as drug interactions or prescribing medications not on the formulary.

Thank God I am a physician.

Joseph E. Johnston, MD
Associate Editor

Letters

To The Editors: Journal MSMA

"It's just not fun anymore!" These are the words of my 76 year old father-in-law, looking back on 50+ years of practice.

"RBRVS, DRG's, PRO, Pre-Admission criteria, etc. -- when will it stop? It was much easier, and much more satisfying dealing with two groups of people - those who could pay and those who could (or would) not. In fact, in 1942, the latter group appeared to be more appreciative and definitely less demanding!"

C.M. Wigfall, Sr., MD, has retired 3 times in the past 11 years, but soon realizes that he is most happy when seeing patients.

His father-in-law, J.N. Rucker, MD of Cannonsburg, Mississippi helped him, and he, in turn, helped me, and still inspires me, and others.

This is a tribute to C.M. Wigfall, MD, and the countless others just like him.

Sincerely,
Walter C. Gough, MD

PAIN MANAGEMENT

The multi-disciplinary treatment team at the Rehabilitation Institute of New Orleans offers comprehensive evaluation and treatment of pain in an inpatient or outpatient setting.

The following services are offered in the Rehabilitation Institute of New Orleans Pain Unit:

- Comprehensive Evaluations
- Work Capacity Evaluation
- Work Hardening
- Physical Therapy
- Occupational Therapy
- VOC
- Nursing
- Recreational Therapy
- Psychology
- Bio Feedback
- Stress Management
- Nerve Blocks

RINO

REHABILITATION INSTITUTE OF NEW ORLEANS
AT F. EDWARD HEBERT HOSPITAL

TELEPHONE:
(504) 363-2200
TOLL-FREE:
1-800-426-3085

One Sanctuary Drive • New Orleans, Louisiana 70114
REHAB DIVISION OF NME

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi
Phone 352-4091

"Current Opinions"

of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON SOCIAL POLICY ISSUES

HIV Testing

HIV testing is appropriate and should be encouraged for diagnosis and treatment of HIV infection or of medical conditions that may be affected by HIV. Treatment may prolong the lives of those with AIDS and prolong the symptom-free period in those with an asymptomatic HIV infection. Wider testing is imperative to ensure that individuals in need of treatment are identified and treated.

Physicians should ensure that HIV testing is conducted in a way that respects patient autonomy and assures patient confidentiality as much as possible. The physician should secure the patient's informed consent specific for HIV testing before testing is performed.The limits of a patient's confidentiality should be known to the patient before consent is given. Because of the need for pretest counseling and the potential consequences of an HIV test on an individual's job, housing, insurability, and social relationships, the consent should be specific for HIV testing.

When a health care provider is at risk for HIV infection because of the occurrence of contact with potentially infected bodily fluids, it is appropriate to test the patient for HIV infection even if the patient refuses consent. When testing without consent is performed in accordance with the law, the patient should be given the customary pretest counseling.

Exceptions to confidentiality are appropriate when necessary to protect the public health or when necessary to protect individuals, including health care workers, who are endangered by persons infected with HIV. If a physician knows that a seropositive individual is endangering a third party, the physician should (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities: and (3) if the authorities take no action, notify the endangered third party.

In order to limit the public spread to HIV-infected individuals because they are HIV seropositive or because they are unwilling to undergo HIV testing, except in the instance where knowledge of the patient's HIV status is vital to the appropriate treatment of the patient. When a patient refuses to be tested after being informed of the physician's medical opinion, the physician my transfer the patient to a physician who is willing to manage the patient's care in accordance with the patient's preferences about testing. ❑

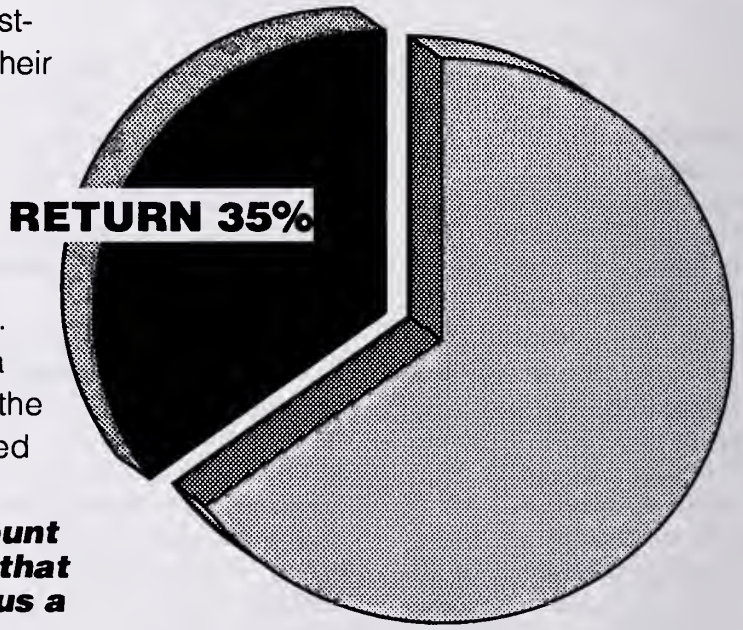
In 1991 our retirement funds earned an average 35% return on investments.*

Employer Plus offers our clients a family of select mutual funds, from one of the nation's leading investment banking firms, to use for their retirement plan investment.

Recent figures for the year 1991, show the ten mutual funds that we most recommended for our clients, averaged a **35%** overall return. One of the ten produced over a **56%** return. the highest, while the lowest return of the ten produced just under a **20%** return.*

If your retirement account is not producing a return that you are happy with, give us a call.

We can help.



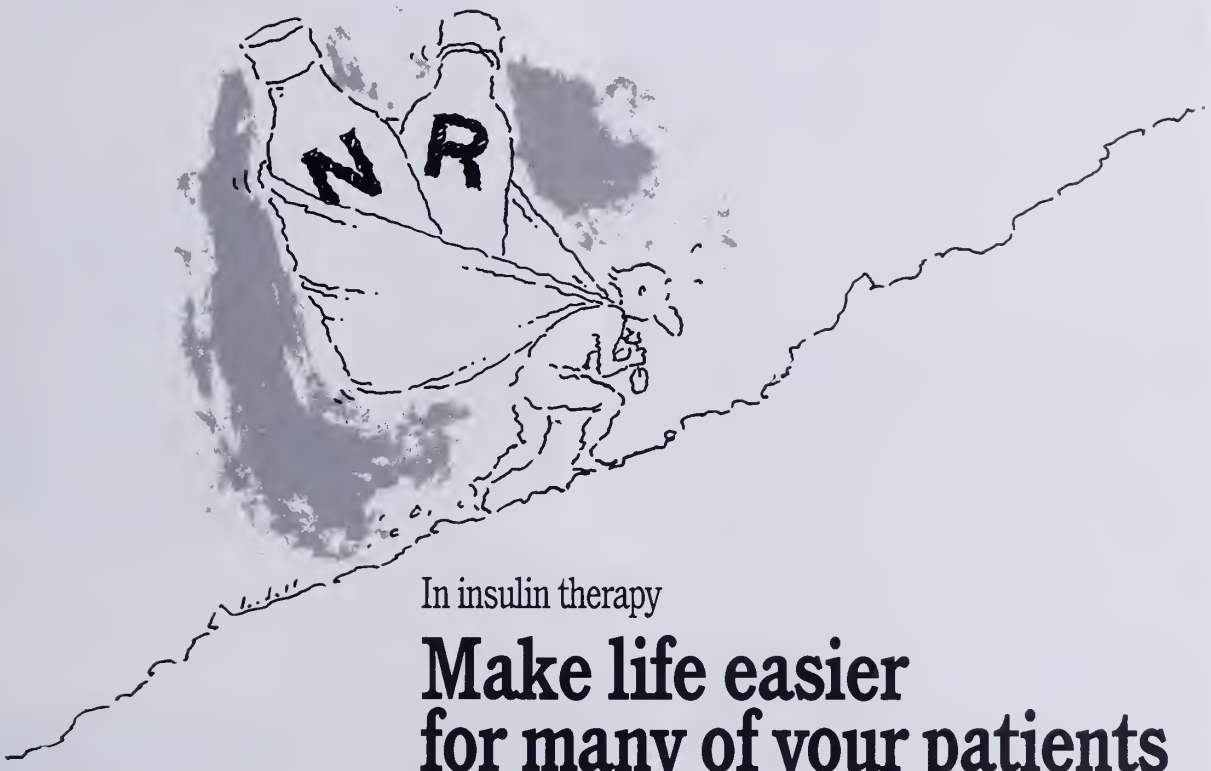
Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

**Past performance is no guarantee of future returns.*

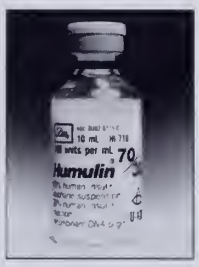
© 1992 Employer Plus. All rights reserved.



In insulin therapy

Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer. No more mixing. No more mixing errors. All of which makes living with diabetes a little easier for patients. And compliance a lot easier to achieve.



Humulin® 70/30

70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

The patient-friendly premix

Global Excellence in Diabetes Care

Eli Lilly and Company
Indianapolis, Indiana
46285

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

HI-7905-B-249327 ©1992, ELI LILLY AND COMPANY

Medical Organization

AMA 141st Annual Meeting



Dr. Sidney O. Graves, Jr. of Natchez served as Chairman of both the Southeastern Delegation and the AMA Convention Committee on Rules and Credentials.



The Mississippi Delegation met each morning to review reports and discuss the activities of the day.





Members of the Mississippi Delegation, above and left, listened to lengthy discussions while the AMA House was in session.





Above left, Dr. George McGee and Dr. Michael Carter listen to items presented in Reference Committee F. Dr. J. Edward Hill, above right, served as Chairman of Reference Committee F and presented the committee's report to the full House of Delegates.



At right, members of the Mississippi Delegations participating in the House of Delegates.





At far right, Dr. James C. Waites of Laurel attended Reference Committee A and reported on the discussion for the entire Mississippi Delegation. At right, Dr. Alton Cobb and Student Member Section Representative Kirk Mullins attended and reported on Reference Committee D.

Five Delegates Receive Membership Jackets

Five members of the Mississippi Delegation were presented membership jackets during the AMA Annual Session. Four received jackets as MSMA Delegates and one from the American College of Allergy and Immunology. Not pictured here but receiving a jacket was Dr. Lamar Weems, of Jackson.



Dr. Candace Keller, right, received her jacket from AMA Vice-Speaker Richard F. Corlin, MD, left, as Dr. James S. Todd, AMA Executive Vice President, looked on.



Dr. Fred McMillan, right, received his jacket from AMA Speaker of the House Daniel H. Johnson, MD.



Dr. George Magee, right, received his jacket from AMA Speaker of the House Daniel H. Johnson, MD.



Dr. Faser Triplett, served as an AMA delegate and received his jacket from the American College of Allergy and Immunology. At the concluding session of the AMA House, Dr. Triplett announced his candidacy for the American Medical Association Board of Trustess in June of 1993.



Representing Mississippi in the AMA Auxiliary House of Delegates were, *front row from left*, Peggy Crawford, MSMA Auxiliary president-elect; Sylvia Walker, MSMA Auxiliary immediate past president; Kathy Carmichael, MSMA Auxiliary president; *back row from left*, Jean Hill past president AMA Auxiliary; Merrell Rogers, AMA National Membership Committee member; Nancy Lindstrom, AMA ERF Committee member and Jeanne Morrison, MSMA Auxiliary delegate.

Dr. Campbell Honored by St. Dominic's

Dr. Guy Campbell was recently honored by St. Dominic Hospital and the Medical Staff of the hospital, when the Magnolia Room in the Education Services Department was renamed the Campbell Room. Dr. Campbell is presently serving as part-time Director of Medical Education at St. Dominic's.

Dr. Bill Causey made the announcement and presented the plaque to Dr. Causey at the June 16, Tuesday Clinical Conference at St. Dominic's. A large group of Dr. Campbell's associates, friends and former students were on hand to honor him. "Dr. Campbell has taught almost everyone in this room," Dr. Causey said at the presentation. "He holds a unique place in our medical community."

"I am humbled at having this kind of recognition," Dr. Campbell commented at the surprise announcement. "The honor is way beyond anything I have ever done and I thank you."

Since 1956, Dr. Campbell has held appointment as Clinical Instructor in Medicine, Clinical Assistant Professor of Medicine, Clinical Associate Professor of Medicine, Associate Professor of Medicine and Professor of Medicine at the University of Mississippi Medical Center. In these capacities, he has been a strong influence on all physicians in training at UMC.

A native of Lauderdale, Dr. Campbell received his Bachelor of Science Degree, Magna Cum Laude, in 1946 from the University of Mississippi. He received his Medical Certificate, Summa Cum Laude, in 1947. In 1949 he received his Doctor of Medicine degree from Harvard Medical School. From there, Dr. Campbell served an internship at Charity Hospital in New Orleans; Pulmonary Disease Residency at Mississippi State Sanatorium; and Internal Medicine Residency at the Veterans Administration Hospital in New Orleans. He has been a Diplomate of the American Board of Internal Medicine since 1958 and Diplomate of Subspecialty Board of Pulmonary Disease since 1965. ◻

THERE *IS* INSURANCE FOR THE UNINSURABLE.

You see them most every day — patients who, because of an injury, chronic illness or congenital disease, cannot find an insurer to cover their medical expenses. They are left to pay their bills any way they can. It's a burden on them. It's a burden on you.

Now there is a solution.

The Mississippi Comprehensive Health Insurance Risk Pool Association offers a comprehensive major medical benefits plan to Mississippians who can otherwise afford insurance but are unable to obtain it due to health conditions.

Operational since January, 1992, the policy offered by the Risk Pool Association contains a maximum benefit of $250,000 and a choice of yearly deductibles of $1,000 or $2,000. There is a one-year pre-existing condition limitation.

You can make a difference.

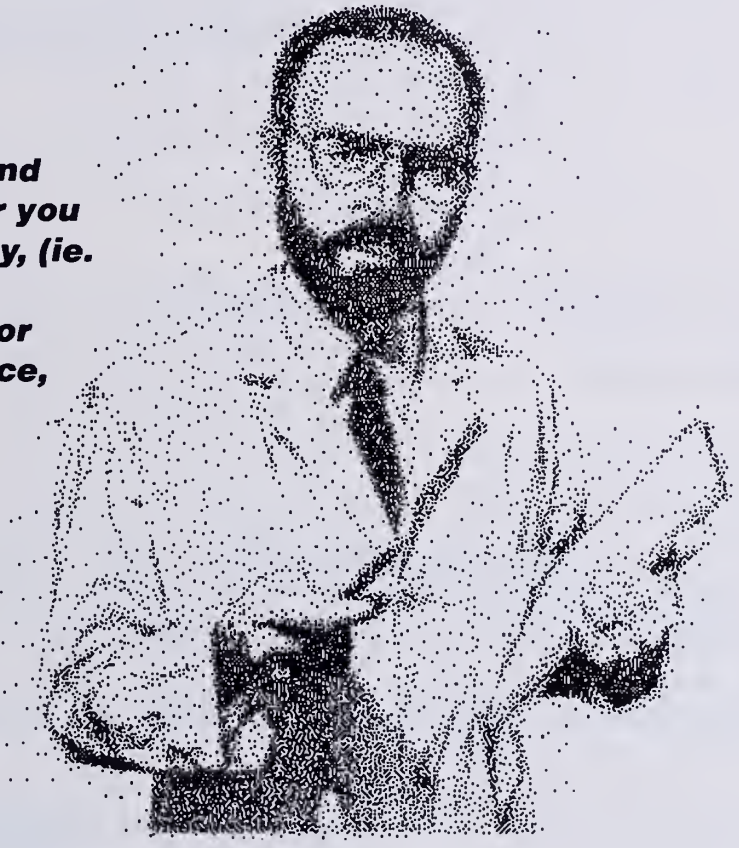
Since the program is new, its benefits are not widely known. You can help spread the word. If you have patients who cannot obtain health insurance because of injury, chronic illness or congenital disease, have them contact their local insurance representative or the Risk Pool Association. The Association benefit plan is administered by Blue Cross & Blue Shield of Mississippi.

If you have any questions about the Mississippi Comprehensive Health Insurance Risk Pool Association, call Lanny Craft at **(601) 362-0799**.

MISSISSIPPI
COMPREHENSIVE
HEALTH INSURANCE
RISK POOL ASSOCIATION

P.O. Box 13748 • Jackson, MS 39236-3748

What can Employer Plus do for me personally, as a doctor?



For every dollar you spend on benefits for you and your family, (ie. health dental, disability, life or vision insurance, as well as dependent care or medical costs) we can save you at least 38 cents in Federal and State taxes on each dollar you are currently spending.

The choice is yours, do you continue to pay your money to the government or do you put more money in your pocket? Contact Employer Plus today, we'll discuss all the details on a personal and confidential basis. Call us

Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.

From the University of Mississippi Medical Center

Mark Wall Named Director of UMC Medical Pavilion

Mark Wall of Madison has been named director of the University Medical Pavilion at the University of Mississippi Medical Center. He assumed the post June 18.

Mr. Wall previously was director of respiratory therapy for the University Hospitals and Clinics, a position he held for 11 years. He also is an assistant professor of respiratory therapy in the School of Health Related Professions.

A graduate of Ottawa University in Ottawa, Kansas, Wall earned a BA in health care and administration in 1979. He is a 1991 graduate of Millsaps College where he earned a master of business administration. Wall also attended the Biosystems Institute School of Respiratory Therapy in Phoenix, Arizona and received an associate degree from Hinds Community College in 1974.

"Mark is an asset to the facility. We are delighted to have his managerial experience and educational background to apply to the Pavilion operation," said Dr. A. Wallace Conerly, Assistant Vice Chancellor at the Medical Center.

The UMC Pavilion houses the largest multi-specialty medical practice in the state. Its physicians, many of whom are the only specialists of their kind in Mississippi, are all on the faculty of the School of Medicine at the Medical Center. Wall will direct the administrative and ancillary operations of the facility. ❑

Dr. Philip Merideth Named 1992 AMA/Burrough Wellcome Fellow

Dr. Philip Merideth, a psychiatric resident, at the University of Mississippi Medical Center, received a 1992 AMA/Burroughs Wellcome Fellowship. This national distinction granted to residents demonstrating leadership potential and a commitment to community service. Dr. Merideth is one of 50 residents nationally to receive the $2,000 fellowship.

In addition to his residency, Dr. Merideth is a 1991 cum laude graduate of the University of Mississippi School of Law, and will take the Mississippi bar exam in July. Despite the rigors of law and medicine, he counsels youth, volunteers at the clinic and works with an anti-drug program. These combined efforts earned him this award.

"It is exciting to have this opportunity," said Dr. Merideth, who, as a AMA/BW fellow, attended the annual convention of the AMA during June in Chicago. He also will attend an interim AMA meeting in December in Nashville.

A 1987 graduate of the UMC School of Medicine, Dr. Merideth is a volunteer with the Lawyer-Doctor-Teacher Drug Awareness Program in Jackson. Sponsored by the Mississippi Bar Association, the program examines the medical and legal effects of drugs on youth. Dr. Merideth also is a volunteer physician with Jackson's Community Stewpot Clinic and volunteers with the Hinds County Youth Detention Center.

Dr. Merideth plans to practice forensic psychiatry which will allow him to practice medicine and still be actively involved in legal issues. "Most people who hold MDs and JDs practice one of the other. I intend to use both degrees." said Dr. Merideth. He estimates that there are about 2,000 MD/JDs in the country. His bother David Merideth will soon join their ranks. A 1982 graduate of the UMC

School of Medicine, David is currently enrolled in the University of Mississippi School of Law.

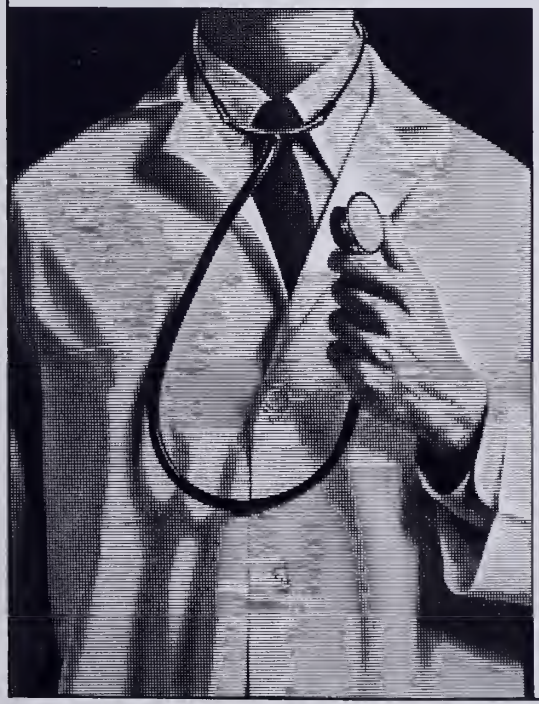
Dr. Philip Merideth, son of former state Representative Sonny Merideth of Greenville, is scheduled to complete his residency in 1995.

The MSMA 125th Annual Session
April 28 - May 2, 1993
Royal d'Iberville Hotel
Biloxi, Mississippi

The Delta Region AIDS Education and Training Center grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN, Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street, Jackson, MS 39216-4505

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect .

ARMY HEALTH CARE TEAM
(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.



Taking A Lesson From Nature.

Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

The same is true of The Doctors' Company. We work with our doctors, not against them, by proving the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more Mississippi physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 16,000 members nationwide. But unlike the migrating geese, we're in Mississippi to stay. We've never left a state to which we've committed service.

The Doctors' Company. Call us today.

More than 16,000 doctors nationwide call us *their* company.

THE DOCTORS' COMPANY

The Largest Doctor-Owned, Doctor-Managed Insurer in the USA

Represented in Mississippi by:
Sampson, Howard & Ashcraft
P.O. Box 12429
Jackson, MS 39236-2429
(800) 898-0373
(601) 956-3720

New Members

Blaylock, Russell L., Jackson. Born Monroe, LA, November 5, 1945; MD, Louisiana State University School of Medicine, New Orleans, LA, 1971; interned and neurosurgery residency Medical University of South Carolina College of Medicine, Charleston, SC, 1971 - 1977; elected by Central Medical Society.

Donahoe, Edgar N., Jr., Indianola. Born Indianola, MS, January 8, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned and family practice residency, University of Alabama School of Medicine, Tuscaloosa, AL, 1989 - 92; elected by Delta Medical Society.

Dunsford, Harold A., Jackson. Born Boston, MA, October 23, 1941; MD, University of Maryland School of Medicine, Baltimore, MD, 1969; interned, same, for one year; pathology residency Peter Bent Brigham Hospital, Boston, MA, 1970-74; elected by Central Medical Society.

Eggert, Roger A., Biloxi. Born Lansing, MI, April 8, 1933; MD, University of Michigan Medical School, Ann Arbor, MI, 1958; interned one year Rochester General Hospital; surgery residency, Same, one year; ENT residency, University of Illinois College of Medicine, Chicago, IL, 1960-63; elected by Coast Counties Medical Society.

Elmore, Gary S., Leakesville. Born Leakesville, MS, May 22, 1933; MD, University of Tennessee College of Medicine, Memphis, TN, 1964; interned one year Mobile General Hospital, Mobile, AL; elected by South Mississippi Medical Society.

Fratkin, Jonathan D., Jackson. Born Brooklyn, NY, September 22, 1944; State University of New York Downstate Medical Center, Brooklyn, NY, 1970; interned & anatomic pathology 1970-72 University of Iowa College of Medicine, Iowa City, IA; ophthalmology residency, same 1974-77 and neuropathology, same, 1978-82; elected by Central Medical Society.

Fredericks, Ruth K., Jackson. Born Greenville, MS, February 15, 1958; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; interned one year NC Baptist Hospital & Wake Forest University, Winston-Salem, NC; neurology residency, same, 1988-91; neuro-oncology fellowship, Duke University Medical Center, Durham, NC, 1991-92; elected by Central Medical Society.

Gelder, Maurice D., Gulfport. Born Belgium, July 31, 1930; MD, University of Lausanne School of Medicine, Switzerland, 1967; interned one year Charity Hospital, New Orleans, LA; psychiatry residency, Tulane University School of Medicine, New Orleans, LA, 1968-71; elected by Coast Counties Medical Society.

Haltom, J Mack, III, Jackson. Born Pascagoula, MS, May 15, 1961; MD, University of Mississippi School of Medicine, Jackson. MS, 1987; radiology residency, University of Texas South Western Medical Center, Dallas, TX, 1987-91; radiology MRI fellowship, Baylor University Medical Center, Dallas, TX, 1991-92; elected by Central Medical Society.

Herrington, Ronald G. Jackson. Born Canton, MS, August 2, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; medicine internship & ophthalmology residency University Medical Center, Jackson, MS, 1987 - 91; glaucoma fellowship, LSU University Eye Center, New Orleans, LA, 1991-92; elected by Central Medical Society.

Hitt, Kevin L, Meridian. Born Poplar Bluff, MO, July 19, 1959; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year Baptist Medical Center, Birmingham, AL, 1988-89; anesthesiology residency University of Kentucky Medical Center, Lexington, KY, 1989-90 and University of Alabama Medical Center, Birmingham, AL, 1990-92; elected by East Mississippi Medical Society.

Johnson, Stephen P., Laurel. Born East St. Louis, IL , July 21, 1957; DO, University of Osteopathic Medicine and Health Sciences, Des Moines, IA, 1985; interned one

year Normandy Osteopathic Hospital, Normandy, IA; medicine residency and gastroenterology fellowship, Kennedy Memorial Hospital , NJ, 1988-92; elected by South Mississippi Medical Society.

Jordan, Scott B., Meridian. Born Shreveport, LA, August 31, 1955; MD, University of South Alabama College of Medicine, Mobile, AL, 1984; interned and ob-gyn residency, Oschsner Foundation Hospital, New Orleans, LA, 1984-88; elected by East Mississippi Medical Society.

Kendrick, Leland R., Bay St Louis. Born Picayune, MS, July 26, 1952; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned and family practice residency, University Medical Center, Jackson, MS, 1989-92; elected by Coast Counties Medical Society.

Lake, Mary Elizabeth, Jackson. Born Houston, TX, May 1, 1959; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year, Memorial Hospital & New York Hospitals, New York, NY; anesthesiology residency Cornell Medical Center, New York, NY, 1989-92; elected by Central Medical Society.

Lawrence, William Keith, Tupelo. Born New Albany, MS, March 26, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned and radiology residency University of Kentucky College of Medicine, Lexington, KY, 1988-92; elected by Northeast Medical Society.

Lincoln, Stephen R., Jackson. Born Little Rock, AK, February 2, 1960; MD, University of Arkansas School of Medicine, Little Rock, AK, 1986; ob-gyn residency East Carolina University School of Medicine, Greenville, NC, 1986-90; reproductive endocrinology fellowship, University of Louisville School of Medicine, Louisville, KY, 1990-92; elected by Central Medical Society.

Loiacano, Dale P., Bay St Louis. Born New Orleans, LA, November 4, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; interned one year family practice, LSU, Bogalusa, LA; anesthesiology residency LSU, New Orleans, LA, 1989- 92; elected by Coast Counties Medical Society.

Lyell, Mark S., Pascagoula. Born Mayfield, KY, Jan 24, 1961; MD, University of Louisville School of Medicine, Louisville, KY, 1987; interned one year University of Tennessee School of Medicine, Memphis, TN; urology residency, Same, 1988-89 & Oklahoma University School of Medicine, Oklahoma City, OK, 1989-92;elected by Singing River Medical Society.

Mauldin, Chris L., Laurel. Born June 7, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned and family practice residency, University Medical Center, Jackson, MS, 1989-92; elected by South Mississippi Medical Society.

You'll love working with our locum tenens physicians and allied health care professionals.
WE GUARANTEE IT.

CompHealth has thoroughly credentialed physicians and allied health care providers from more than 40 fields of specialization available to provide locum tenens, or temporary, staffing assistance when and where you need it.

Plus, we have the standards and experience to guarantee your satisfaction each time we place a member of our medical staff in your practice or facility. It's the closest thing you'll find to a risk-free way to cover for absent staff members, "try out" a potential new recruit, or take care of your patients while you search for a new full-time associate.

Call us today to arrange for quality locum tenens coverage, or to discuss your permanent recruiting needs.

CompHealth
COMPREHENSIVE HEALTH CARE STAFFING

1-800-453-3030
Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

Norton, Timothy W., Hattiesburg. MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned and anesthesiology residency, same, 1988-92; elected by South Mississippi Medical Society.

Pearson, Eric J., Meridian. Born Ann Arbor, MI, October 30, 1959; MD, Medical University of South Carolina College of Medicine, Charleston, SC, 1988; interned and anesthesiology residency University of Alabama School of Medicine Baptist Hospitals, Birmingham AL, 1988-92; elected by East Mississippi Medical Society.

Rushing, Eric L., Jackson. Born Brookhaven, MS, November 2, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; interned one year Baptist Medical Center, Birmingham, AL; radiology residency, University Medical Center, Jackson, MS, 1988-92; elected by Central Medical Society.

Teeter, Mark D., Jackson. Born Honolulu, HI, August 14, 1962; MD, University of Arkansas School of Medicine, Little Rock, AK, 1988; interned and anesthesiology residency, University Medical Center, Jackson, MS, 1989-92;elected by Central Medical Society.

Thompson, David M., Vicksburg. Born Calhoun, GA, August 31, 1961; MD, Medical College of Georgia, School of Medicine, Augusta, GA, 1987; interned and orthopaedic surgery residency, same, 1987-92; elected by West Mississippi Medical Society.

Werhan, Carol F., Jackson. Born Tupelo, MS, April 21, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned and anesthesiology residency University Medical Center, Jackson, MS, 1988-92; elected Central Medical Society.

Whitehead, Kary G, Meridian. Born Laurel, MS, March 18, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, ;1986; interned one year University of Virginia School of Medicine, Charlottesville, VA; medicine residency, same, 1987-89; pulmonary/critical care fellowship, University of Tennessee School of Medicine, Memphis, TN, 1989-92; elected by East Mississippi Medical Society.

Wolben, Martyn D., Vicksburg. Born St. Petersburg, FL, November 13, 1956; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned and ob-gyn residency Bayfront Medical Center, St. Petersburg, FL, 1988-92; elected by West Mississippi Medical Society.□

Deaths

Blake, Thomas H., Jackson. Born Jackson, MS, June 23, 1904; MD, University of Tennessee School of Medicine, Memphis, TN, 1929; interned one year Memphis General Hospital, Memphis, TN; surgical pathology residency 6 months, Johns Hopkins Hospital, Baltimore, MD; orthopaedic surgery residency Campbell Clinic, Memphis, TN, 1931-33; died June 22, 1992 age 87.

Shaw, Thomas R., Lucedale. Born Webster County, November 10, 1934; MD, University of Mississippi School of Medicine, Jackson, MS, 1964; interned one year Mobile General Hospital, Mobile, AL, died June 29, 1992, age 57.

Tatum, A. T., Hattiesburg. Born Petal, MS, May 15, 1915; MD, University of Tennessee College of Medicine, Memphis, TN, 1940; interned one year Baptist Memorial Hospital, Memphis, TN; died July 2,1992, age 79.□

FOR COMMENTS OR QUERIES

The Editors of *Journal MSMA* invite you to comment on any material that appears in or is absent from the publication. If you have a query or comment, please sent it to: The Editor, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

American Medical Association

Physicians dedicated to the health of America

For Your Benefit

American Medical Association Works to Redress Medicare Inequities

The American Medical Association is working to enact legislation in Congress to redress several inequities in the Medicare program.

New Physicians: Senate bill 2362 and House bill 4507 ask for repeal of provisions in the current law that mandate Medicare payment reductions for physicians in their first four years of providing care for Medicare beneficiaries.

EKGs: House bill 3373 and Senate bill 1810 would restore Medicare reimbursement for interpreting EKGs. HCFA says that it did not add sufficient money to visit codes to cover expected costs of paying for interpretation. The AMA, HCFA and medical specialty societies are discussing ways to recoup the money.

Geographic Price Cost Indices: HR 4393 and S 2680 would require HHS to use more accurate current data and consult with the state medical societies to revise the GPCIs. S 2683 requires HCFA to update GPCIs more frequently and make special adjustments for physicians in isolated areas.

Anti-Hassle: HR 2695 and S 1332 aim at reducing administrative hassles regarding secondary payors, payment errors, carrier user fees, and improving physician peer review.

Contact your senators and representatives to ask them to cosponsor these bills: 1-202-224-3121.

AMA Censures Disruptive CLIA Office Visits

The AMA, in comments on the final CLIA regulations, characterized unannounced HCFA inspections as disruptive for patients, especially those waiting for test results. The AMA recommended that inspectors:

- treat physician's offices differently from independent reference labs, and
- notify physicians ahead of time.

The AMA and Medical Liability: Principles of Reform

The American Medical Association believes that as the national debate on health care reform proceeds, we must address its high cost, inefficiency and inequity of our medical liability system.

The Problem

People injured by medical malpractice or defective medical products are entitled to fair and prompt compensation for their injuries. All parties should have the right to fair and cost-effective dispute resolution. The AMA believes that in resolving medical and product liability claims, the civil justice system currently:

- Costs too much and works slowly;
- Fails to provide access to the legal system or fair compensation to most patients, while providing exorbitant awards to others;
- Is unable to promptly or cost-effectively identify unfounded claims;
- Fails to promote quality health care or protect patients from avoidable injuries;
- Adds billions annually to the national health care bill in medical liability premium costs and by encouraging doctors to practice "defensive medicine" to hedge against potential lawsuits;
- Threatens access to health care, especially high risk services, such as obstetrics and emergency room care;
- Unnecessarily adds to the cost of pharmaceuticals and medical devices, and
- Inhibits health care product research and development, reducing the availability of potentially valuable new drugs and medical devices.

The impact of our medical liability system has been studied extensively. These studies agree that this inefficient system adds to the serious problems of making health care services available to all and making these services cost-effective.

The federal government, as the single largest purchaser of health care services, has a strong interest in promoting available and quality medical care and managing its cost. Because of that concern, it should take the lead to address medical liability problems.

Principles of Medical Liability Reform

The over 100 groups including the AMA that participate in the **National Medical Liability Reform Coalition** support the principles articulated below. These principles should guide any restructuring of the current medical liability system.

1. **Availability of Health Care:** A compensation system for medical injury should promote the basic goal of providing access to all necessary health care service to all.
2. **Quality of Health Care:** A compensation system for medical injury should deter substandard or unethical practices and encourage improvements in the safety and quality of medical care.
3. **Patient-Professional Relationship:** A compensation system for medical injury should enhance a cooperative relationship between patient and providers, based on mutual respect and effective communication.
4. **Fair Compensation:** A compensation system for medical injury should compensate patients injured by malpractice adequately and equitably.
5. **Prompt Resolution:** A compensation system for medical injury should resolve claims promptly.
6. **Innovation:** A compensation system for medical injury should encourage innovation in diagnosis and treatment, leading to better care.
7. **Predictability:** A compensation system for medical injury should provide predictable outcomes with respect to findings of liability and amount of awards.
8. **Cost Effectiveness:** A compensation system for medical injury should operate efficiently and economically.

We urge the Congress and the President to work on meaningful medical liability reform legislation consistent with the above principles.

Personals

Horace H. Baggett, W. Darrell Burnham, Joe H. Campbell, L. Scott Gilliam, Joe N. Leigh, A. Gordon Lyons, David S. Reynolds, Denise W. Reynolds, Bobby D. Smith, and William B. Strong, Jr. all anesthesiologists in Hattiesburg, have incorporated their individual practices to become South Mississippi Anesthesia Associates, PA, (SMAA) 2601 Mamie Street, Suite 202 Medical Plaza, Hattiesburg. Also joinng them are **David L. McKellar**, of Statesville, North Carolina and **Timothy W. Norton** of Jackson .

Nan C. Brantley and **Elizabeth C. Henderson** are proud to announce their association together and the relocation of their practices in Psychiatry to 1855 Lakeland Drive, Suite J-10, Jackson.

Gloria Jean Butler of Port Gibson, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Michael R. Byers has associated with the Jackson Medical Associates, PA in the practice of infectious diseases and internal medicine.

Neil Thomas Carstens has associated with **Wayne T. Lamar** for the practice of orthopaedic surgery and sports medicine, 2168 Lamar Boulevard, Oxford.

Vernon Chase and **William C. Kellum** of Tupelo announce the opening of the Baldwyn Family Medical Clinic, 745 Highway 45 South, Baldwyn.

Michael W. Coleman of Greenwood has associated with **Lowell Jones**, 224 Virginia Street, Indianola.

Frederick T. Duggan, has associated with Internal Medicine Clinic, 1504-20th Avenue, Meridian, in the practice of Pulmonary Medicine.

Roger A. Eggert announces the opening of his practice for Ear, Nose & Throat, Medical Plaza Building, 111 Lameuse Street, Suite 107, Biloxi.

George Ellis has associated with the Florence Family Doctors for the practice of Family Medicine.

Thomas R. Flores announces the relocation of his office to: 835 Hancock Square, Suite C, Highway 90, Bay St. Louis.

Joiner Mack Halton, III has associated with Radiological Group, PA, 1405 North State Street, Jackson, for the practice of Diagnostic Radiology.

John R. Harper of Taylorsville has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Elizabeth C. Henderson and **Nan C. Brantley** are proud to announce the association together and the relocation of their practices in Psychiatry to 1855 Lakeland Drive, Suite J-10, Jackson.

John G. Holland has associated with the Hattiesburg Clinic in the practice of Obstetrics/Gynecology.

Jack C. Hoover of Pascagoula, a obstetrician/gynecologist, recently attended a seminar in Atlanta entitled, *Advanced Operative Laparoscopy: Hysterectomy and Hysteroscopy.*

Kurt Johnson has associated with Florence Family Doctors for the practice of Family Medicine.

Dwight S. Keady, Jr., an oncologist, has associated with Meridian Medical Associates, PA.

William C. Kellum and **Vernon Chase** of Tupelo announce the opening of the Baldwyn Family Medical Clinic, 745 Highway 45 South, Baldwyn.

Leland R. Kendrick announces the opening of his practice of Family Medicine, 252 A Highway 90, Bay St. Louis.

Bruce W. Lambuth has associated with The Medical Clinic PA of Jackson for the practice of Medical Oncology.

William Keith Lawrence, has associated with Radiology of Tupelo, PA in the practice of Diagnostic

Radiology.

Michael W. Lowery announces the relocation of his office to 2601 Mamie Street, Suite 205, Forrest Generl Medical Plaza, Hattiesburg.

Mark S. Lyell announces the opening of his medical practice, Gulf Coast Urology Clinic, Medical Arts Building, Suite 102A, 4105 Hospital Road, Pascagoula.

Rebecca Lyons announces the opening of her practice for the treatment of Allergic and Sinus Problems, 297 Highway 51 N, Victoria Station, Suite C, Ridgeland.

Michael W. Lowery announces the relocation of his office to 2601 Mamie Street, Suite 205, Forrest General Medical Plaza, Hattiesburg.

David G. McHenry announces the closing of the Meridian Neurological Clinic for the purpose of relocation to St. Dominic's Medical Tower, Jackson.

Everett C. McKibben has associated with The Laird Clinic of Family Medicine, 103 Doctors Park, Starkville.

Dennis P. Morgan has associated with the Medical Clinic PA of Jackson for the practice of Medical Oncology.

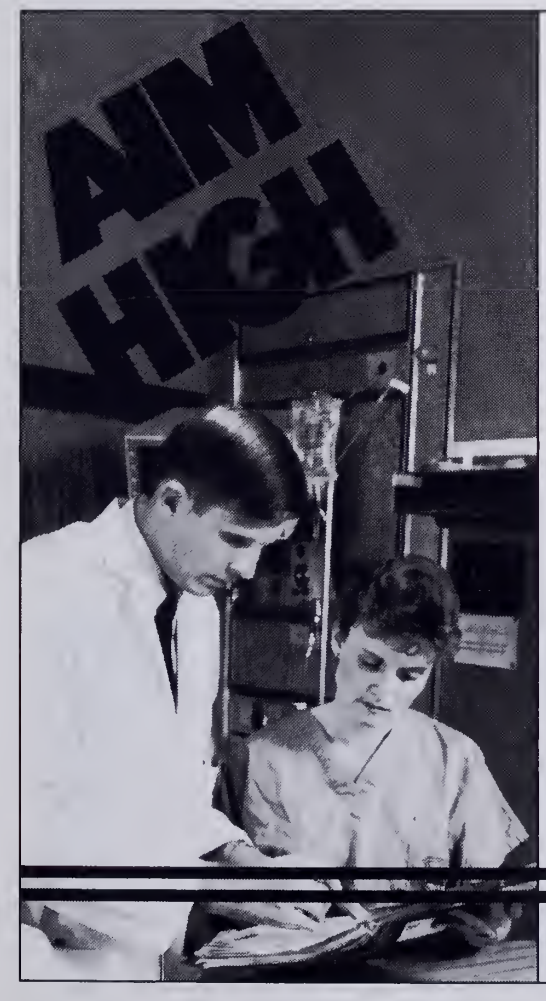
Kevin Nichols announces the relocation of his practice to 913 Holland Avenue, Philadelphia.

Tammie Bayne Parker has associated with Hinds Internal Medicine Clinic, PA for the practice of Internal Medicine, 1983 McDowell Road, Jackson.

Mark T. Phillips has associated with **Robert M. Graham** and **Robert E. Dilworth** for the practice of Urology, 1302 Twentieth Avenue, Meridian.

Calvin P. Poole, Jr., has associated with The Street Clinic, Vicksburg, in the practice of Obstetrics and Gynecology.

Kenny K. Robbins, has associated with The Newborn Group, Jackson.



BE AN AIR FORCE PHYSICIAN.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle and benefits you enjoy as an Air Force professional, along with:

- 30 days vacation with pay per year
- Dedicated, professional staff
- Non-contributing retirement plan if qualified

Today's Air Force offers the medical environment you seek. Find out how to qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE 1-800-423-USAF

AIR FORCE

Physicians' Recognition Award

Ten MSMA members were named recipients of the AMA Physicians' Recognition Award in June 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by medical society.

Central Medical Society
Fred H. Ingram, MD
Ronald P. Krueger, MD
T. W. Talkington, MD

Desoto County Medical Society
Henry W. Wadsworth, MD

Northeast Mississippi Medical Society
Edward Kirkham Gore, MD

South Mississippi Medical Society
Charles P. Bass, MD
Larry Hale Day, MD
G. O. Runnels, MD
David B. Stephens, MD

Singing River Medical Society
Julius A. Bosco, MD

Bruce S. Senter has associated with Mississippi Spine & Orthopedic Center, Jackson, for the practice of Lumbar & Cervical Spine Surgery, Spinal Trauma, and Adult Orthopedics.

Steven W. Stogner has associated with Charles J. Parkman and the Hattiesburg Clinic in the practice of Pulmonary Medicine.

William H. Vaughan, Jr. of Jackson has completed the program is Psychoanalysis in the department of Psychiatry and Neurology at the Tulane University of Louisiana.

Mickey P. Wallace of Jackson is serving as chairman-elect of the MSMA Young Physicians Section.

Kary G. Whitehead has associated with Meridian Medical Associates, PA, in the practice of Pulmonary Medicine.

Martyn Woleben has associated with The Street Clinic, Vicksburg, in the practice of Obstetrics and Gynecology. ◻

Send Items for the
Personals Column
to the
Editor, *Journal MSMA*
PO Box 5229,
Jackson, MS 39296-5229

Placement Service

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

MOONLIGHTING IN MISSISSIPPI



SINCE 1977, PRI-MED HAS BEEN STAFFING EMERGENCY DEPARTMENTS IN MISSISSIPPI, ARKANSAS, TENNESSEE, AND CALIFORNIA. PRI-MED OFFERS A WIDE RANGE OF OPPORTUNITIES FOR THE PHYSICIAN, FROM THE OCCASIONAL NIGHT SHIFT TO THE FULL-TIME EMERGENCY ROOM DIRECTORSHIP. FOR MORE INFORMATION ON MOONLIGHTING IN YOUR AREA PLEASE CALL JOE PAT JUNKIN OR PATSY MCDANIEL AT:

1-800-821-6382 - OUTSIDE TENNESSEE
1-901-685-9305 - IN TENNESSEE

Equal Opportunity Employer

PRI-MED
primary medicine

6263 POPLAR AVENUE, SUITE 700 • MEMPHIS, TENNESSEE 38119

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

Greater Meridian Health Clinic is seeking a Medical Director. The Director will manage an experienced and enthusiastic management team in the area of primary care delivery. Responsibilities include: provider supervision and scheduling, planning, implementation and evaluation of medical services, and oversight of quality assurance programs. Candidates should be Mississippi licensed (licensure eligible), board eligible/certified in Pediatrics, Internal Medicine or Family Practice and should expect to maintain a part-time medical practice at the center. Nice facility, excellent benefits, malpractice paid, paid retirement, good salary. CV's of inquiries should be directed to: Wilbert L. Jones, Executive Director, 2700 6th Street, Meridian, MS 39301 (601) 693-0151 FAX (601) 693-9182.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

Consider becoming a part of EMSA Limited Partnership. In associating with EMSA, you'll be joining a nationwide network of highly skilled, professionally recognized physicians.

Various EM opportunities are available statewide. **Administrative opportunity available in Natchez.** Outstanding employee package including malpractice insurance, health/life/disability for FT positions, CME, and a 401 (K) Plan. Please call or write to:

Carrie Rubin
EMSA Limited Partnership
100 N. W. 70 Avenue
Ft. Lauderdale, FL 33317
1-800-443-3672, Ext. 265
(305) 792-3531 FAX

MEA

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

Family Practice/ ER Physician needed on a regular weekday basis (15 to 20 hours a week) and to work alternate Saturday's. North East Jackson. Call 957-2273.

Excellent Opportunity for Board-Certified or Board Prepared Emergency Physician with interest in teaching residents to join stable, all Board-Certified group. Recently approved Emergency Medicine Residency. Community emergency department with 36,000 visits per year. Excellent first year compensation as independent contractor with early partnership potential. Flexible scheduling with extended double coverage. **Reply to Sarah B. d'Autremont, M.D., FACEP or Marie Wegeman, Baton Rouge General Medical Center, P.O. Box 2511, Baton Rouge, La., 70821. (504) 387-7053.**

Internal Medicine Clinic of Laurel is recruiting an oncologist and rheumatologist for clinic adjacent to modern, fully equipped 275-bed regional medical center. Call John Wallace, MD, at 1-800-654-7918.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

FP, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Merritt, Hawkins & Associates, a national physician search firm based in Irving, TX, is accepting applications for its second annual pro bono physician search program. Each year the firm seeks a physician for a medically underserved community, waiving its $20,000 professional fee.

The no-cost physician placement will be awarded to the community that most clearly demonstrates a protracted and critical need for a physician, according to Merritt, Hawkins & Associates' president James Merritt. Applications can be ordered by calling the firm's corporate office at (800) 876-0500. Applications must be received by November 15, 1992.

A committee of independent health care professionals will review program applications submitted to Merritt, Hawkins & Associates. The committee will evaluate applications based on several criteria. First, applicants must demonstrate critical need for a physician and they must show that serious efforts to recruit a physician have been made. They also must indicate the impact lack of a physician is having on the health care delivery, economy and morale of the community. Finally, consideration will be given to those communities facing a "classic" doctor shortage dilemma.

The pro bono search will include an on-site consultation at the selected community. A vigorous search effort then will be initiated, combining a direct mail campaign, advertising, a physician data base sweep and telephone solicitation of physicians. Merritt, Hawkins & Associates will screen all candidates by telephone and in person and will provide on-site interview consultation. The firm will assist with all contracts and financial packages. Merritt, Hawkins & Associates will continue the search until a placement is made.

Classified

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captain Mike McRaney, (601) 857-9462, PO Box 999, Biloxi, MS.**

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Medical Office Space Available for Lease
Ridgeland, Mississippi

Office space consists of 25 X 40 feet, or 1,000 square feet, available August 15, 1992, located in shopping center on Lake Harbour Drive at Highway 51. Space includes waiting room and receptionist area, private office with rest room, laboratory, 3 examination rooms and patient's rest room. Call 859-5251.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

Items for the Placement Service or Classified Section should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

Index to Advertisers

CancerPay Plus ..... **second cover**
CompHealth 302

Deposit Guaranty Investments **4**
Disability Determination 309
Doctors Insurance Reciprocal **6**

Eli Lilly & Co. - Humulin 291
Employer Plus, Inc. ..... 290 & 297

Harreld Chevrolet-Oldsmobile 278

Medical Assurance Co. of MS ..... **third cover**
Medley & Company 283
Mississippi Comprehensive Health Insurance Risk Pool Association 296
MS Emergency Association 310
MS Physicians Insurance Company 289
MSMA Benefit Plan & Trust ..... **fourth cover**

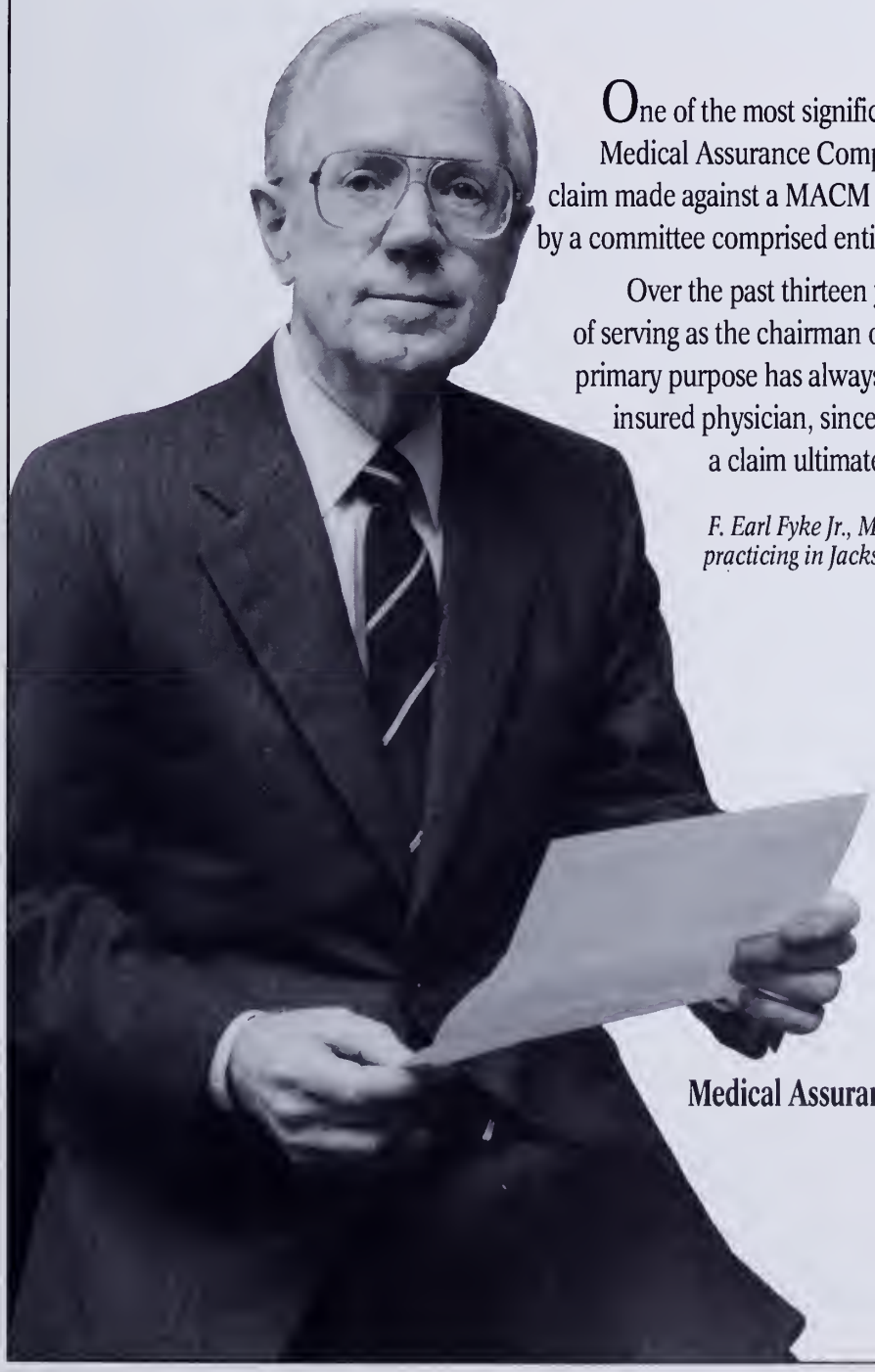
Premier Printing 288
PRI-MED, Inc. 309

Rehabilitation Institute of New Orleans 288

The Doctors' Company 300
Trustmark 311

US Air Force 307
US Army Active 299
US Army Reserve **8**

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



One of the most significant advantages offered by the Medical Assurance Company of Mississippi is that any claim made against a MACM policyholder will be reviewed by a committee comprised entirely of Mississippi physicians.

Over the past thirteen years, I have had the privilege of serving as the chairman of the Claims Committee. Our primary purpose has always been to assist and advise the insured physician, since the decision to resist or settle a claim ultimately rests with the policyholder.

F. Earl Fyke Jr., M.D., is a Board Certified Internist practicing in Jackson.

Medical Assurance Company of Mississippi
1-800-325-4172 or
(601) 353-2000 in Jackson
735 Riverside Drive • Suite 307
Jackson, MS 39202
P.O. Box 4915
Jackson, MS 39296-4915

LIBRARY
AUG 2 6 1992
N.Y. Academy of Medicine
N.Y. ACADEMY OF MED
2E E 103RD ST
NEW YORK NY 10029-5207

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

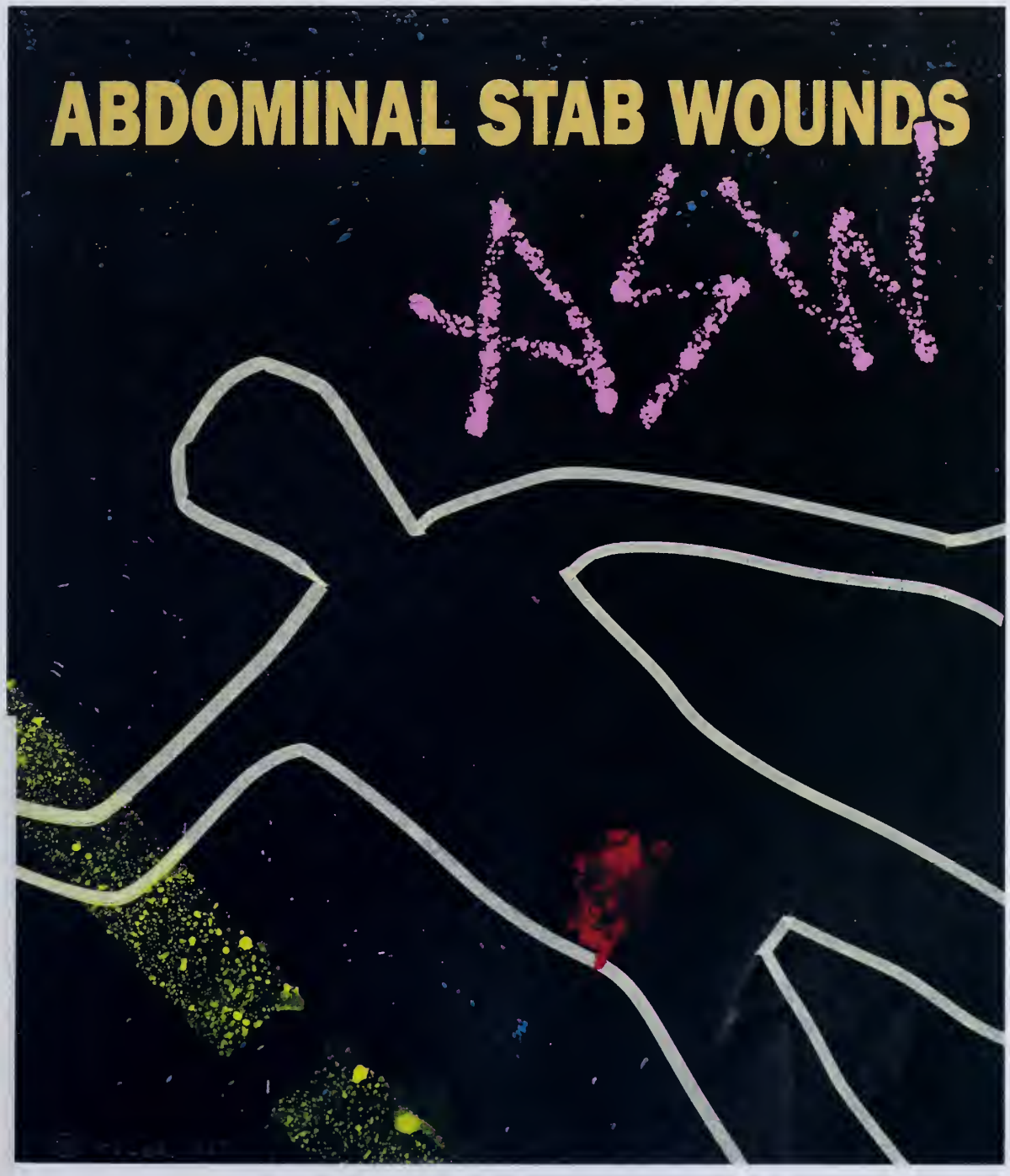
For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

SEPTEMBER 1992



N.Y. ACADEMY OF MED
2E E 103RD ST
NEW YORK NY 10029-5207

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



Medical Assurance Company has proven time and again the benefits of affiliation with a company dedicated to Mississippi physicians. Doctors don't want decisions regarding their practice made by people they have never met with offices thousands of miles away.

When actuarial consultants advised MACM that it might be necessary to raise premiums for pediatricians due to claims losses, the Company spearheaded a mandatory statewide Risk Management Program to address the problem.

By working with us, they were able to reduce losses among pediatricians, thereby avoiding rate increases which would have had a negative impact on health care throughout the State.

MACM insures more Mississippi physicians than any other company for good reason -- they *are* Mississippi physicians. Who could know our needs better?

Dr. Elizabeth Keeling is a Board Certified Pediatrician practicing in Jackson, Mississippi.

MEDICAL ASSURANCE COMPANY OF MISSISSIPPI
1-800-325-4172 or
601/353-2000 in Jackson
735 Riverside Drive ■ Suite 307
Jackson, MS 39202

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

SEPTEMBER 1992 VOLUME XXXIII NUMBER 9

SCIENTIFIC ARTICLES

Grossly Positive Peritoneal Lavage and Nontherapeutic Laparotomy After Abdominal Stab Wound 313
Charles V. Pollack, Jr., MA, MD; Robert C. Jorden, MD, FACEP; Galen V. Poole, MD, FACS and John A. Griswold, MD

Evaluation of Mammographic Calcification 319
W. Mel. Flowers, Jr., MD and Donna S. Launey, MD

SPECIAL ARTICLE

Mississippi State Board of Medical Licensure Annual Report July 1, 1990 through June 30, 1991 323
Frank J. Morgan, Jr., MD

EDITORIALS

President of the Medical Society Syndrome "PMS-S" 328
William C. Gates, MD

Behavior Modification 329
Joseph E. Johnston, MD

DEPARTMENTS

Letters 330
Current Opinons 331
Medical Organization 335
From the University of Mississippi Medical Center 339
New Members 342
Personals 347
Placement Service 352

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
Leslie E. England, MD
and the editors

THE ASSOCIATION
William C. Gates, MD, *President*
Don Q. Mitchell, MD, *President-Elect*
D. Stanley Hartness, MD, *Secretary-Treasurer*
H. Vann Craig, MD, *Speaker*
Eric A. McVey, III, MD, *Vice Speaker*
Charles L. Mathews, *Executive Director*

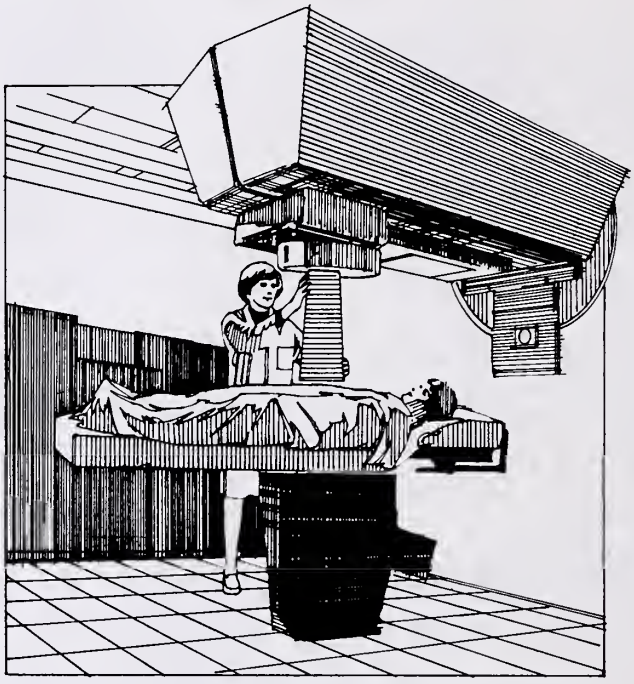
NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6396) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 9

September 1992

Dear Doctor:

Printed materials required through passage of **House Bill 982 -- the "informed consent law"** -- are now available to physicians, hospitals, other facilities, and individuals.

The Fifth Circuit Court of Appeals in New Orleans upheld the Mississippi law in a ruling August 6. That ruling reversed U.S. District Court Judge Henry Wingate's decision which blocked the law from going into effect September 1, 1991.

The informed consent law requires physicians to supply information to each woman requesting an abortion 24 hours before the procedure is performed. The information should include fetus development stages and a list of options and services available to the woman. Referring physicians may supply the information to meet the needs of the 24-hour waiting period.

Request for the 40-page **Informed Consent Information and Resources** booklet should be addressed to the Health Facilities Licensure and Certification Division, Mississippi State Department of Health, P.O. Box 1700, Jackson, MS 39215-1700.

The informed consent law, passed during the 1991 Regular Session, required the Mississippi State Department of Health to publish by August 29, 1991, specific printed materials for "the woman upon whom the abortion is to be performed or induced."

The law also required those materials to be available at no cost, "upon request and in appropriate number to any person, facility, or hospital."

Accordingly, a team of public health professionals -- including physicians, nurses, social workers, analysts, health educators, and health communicators -- developed the publication to meet criteria the Mississippi State Legislature mandated. The Mississippi State Department of Health Office of Health Communications and Public Relations coordinated the production.

Booklets contain descriptive information about the developing child from four through 38 to 40 weeks.

Resources grouped geographically according to Mississippi State Department of Health public health districts include nine categories: district public health offices, county health departments, community health centers, county human services offices -- economic assistance and social services, crisis pregnancy centers, abortion facilities, licensed maternity homes, licensed adoptions agencies, and hospitals with delivery/newborn services.

The MSMA 125th Annual Session
April 28 - May 2, 1993
Royal d'Iberville Hotel, Biloxi, Mississippi

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔	1. Structured for Physician's offices	Savings Up To 15 %
✔	2. Established by Your Association	
✔	3. Savings over what you currently are paying	
✔	4. Responsive to your needs	
✔	5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 825-5064
(800) 748-9713

Sponsored by the Mississippi State Medical Association

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 9

Mississippi Infant Morality Rate Down

Jackson, MS - Mississippi babies got a better start in life in 1991 than ever before, according to vital statistics the Mississippi State Department of Health released in July.

The infant mortality rate -- the number of babies per 1,000 born who die before one year of age -- fell slightly from 12.1 in 1990 to 11.4 in 1991, Mississippi's lowest rate ever.

"No one knows for sure what causes small statistical variations like this, but several things we do know," said state Health Officer Dr. Alton Cobb. The three leading causes of infant death for 1991 were birth defects, sudden infant death syndrome and problems related to premature birth, Cobb said.

A total of 493 babies died in the state last year before their first birthday.

Statewide, the overall infant mortality rate for 1991 showed a white infant mortality rate of 7.4 deaths per 1,000, down from 8.6 in 1990. Non-white death rate was 15.5 per 1,000, down from 15.9 in 1990.

AIDS In Children

Jackson, MS - During 1991, there were 47 infants born to HIV infected women. Of these mothers, 15 (32 percent) are 21 years of age or younger. Among this group, seven were teenagers; the youngest infected mother was 13 years old. Racially, 98 percent are black and 2 percent white. About one in four babies born to mothers infected with HIV will develop AIDS. New tests allow diagnose of babies infected with HIV before they become ill.

At the AIDS clinic located at the Children's Hospital of the University of Mississippi Medical Center, 67 babies were cared for during 1991. Of these babies, 20 had HIV infection and the other 47 are at risk; one died. Since the first baby, there have been 10 deaths among babies infected with this deadly virus. We can expect 45-50 new HIV mothers to deliver each year, and of those 15-20 per year to transmit AIDS to their yet-unborn babies.

MFMC CONDUCTS SERIES OF PRO UPDATE WORKSHOPS

The Mississippi Foundation for Medical Care (MFMC), medical peer review organization for the state, will conduct a series of Pro Update workshops. The workshops are scheduled for September 9 at the Holiday Inn in Grenada; September 22 at the Holiday Inn Metro in Jackson; and September 30 at the Ramada Inn in Hattiesburg.

Area medical personnel are invited to attend the workshop which will address changes in Medicare and Medicaid review.

Registration is 8:30 a.m. with the workshop beginning at 9:00 a.m. There is no charge to attend. For more information or to register for the workshop in your area, contact MFMC communications at 354-0304.

Professionalism

The AMA Member Benefit You Probably Take for Granted

Professionalism: The structure for standard setting and autonomy within the profession.

Last year, the Food and Drug Administration's proposed rules dealing with drug company sponsorship of continuing medical education that could have put an end to even the most valuable, scientifically objective programs.

This year the rules were withdrawn.

Why? Because a professional accreditation process which the American Medical Association conceived of today helps to govern through the Accreditation Council for Continuing Medical Education, stepped in with its own more rational rules and a credible plan to achieve compliance.

Early in the 1980's, Congress created a Federal medical ethics panel that was supposed to establish rational standards for physician conduct on a variety of complex physician-patient ethical issues.

This panel remains virtually dormant; there is little Federal or state legislation on medical ethics.

Why? Because the American Medical Association's Council on Ethical and Judicial Affairs has forcefully dealt with each emerging ethical dilemma within the profession, no matter how controversial. The Council has issued strong guidelines on sexual harassment, gender and racial disparities in health care, HIV patient treatment and testing, withdrawal of life support, assisted suicide, gifts from industry, genetic testing and many other issues.

Medical education and residency training in this country is generally viewed as both the best, and the least regulated by government, in the world.

Why? Because the American Medical Association established, and today staffs, the two voluntary and national accreditation agencies for medical education and residency: the Liaison committee on Medical Education (with the AAMC), which accredits and sets standards for all United States medical schools, and the Accreditation Council for Graduate Medical Education, which accredits all of the country's residency programs.

Similar stories can be told about the AMA's central role in establishing hospital standards, national licensure examinations, standards of practice and risk management.

Because the American Medical Association has been and is there -- establishing and maintaining uniform standards within the profession, inappropriate interference in many areas has been defeated.

There is great power in professionalism, and the AMA was created to be its foundation within the profession. Because of it, you still retain a substantial degree of freedom to do what you believe is best.

Keep the AMA strong, and the profession will be strong ... and medicine will remain the highest professional calling.

American Medical Association

Physicians dedicated to the health of America

Grossly Positive Peritoneal Lavage and Nontherapeutic Laparotomy After Abdominal Stab Wound

CHARLES V. POLLACK, JR., MA, MD
ROBERT C. JORDEN, MD, FACEP
GALEN V. POOLE, MD, FACS
JOHN A. GRISWOLD, MD

Diagnostic peritoneal lavage is often employed in the evaluation of stab wounds of the anterior abdomen and lower chest. This technique is perhaps too sensitive, however, in detecting self-limited solid visceral and abdominal wall injuries. We report five cases of nontherapeutic laparotomies in abdominal stab wound victims who had a grossly positive peritoneal lavage prior to surgery. Previous retrospective data indicate that such "false positive" lavages most commonly result from blood entering the abdominal cavity from the wound, although nonoperative injuries to solid viscera and iatrogenic trauma are sometimes implicated. We review these studies and suggest caution in relying too much on lavage results in determining the need for exploration after abdominal stab wounds. Rather, they must be considered alongside other findings in assessing each individual case.

In the fall of 1989 a prospective study of the utility of diagnostic peritoneal lavage in patients undergoing laparotomy for anterior thoracoabdominal stab wounds was begun. Within the first 40 patients studied, five patients had grossly positive peritoneal lavages but subsequently underwent laparotomies that were nontherapeutic. While this interesting phenomenon is not unprecedented, it has not been previously reported with such a high frequency. We therefore present these five cases while we continue to accumulate data in the study. Possible causes of the false positive aspirations are discussed.

PROTOCOL

All patients presenting to the emergency department (ED) at the University of Mississippi Medical Center with stab wounds of the anterior trunk are considered for inclusion in this ongoing study. Patients are excluded if they are hemodynamically unstable on arrival. All other patients with stab wounds located within the area bounded by the nipple line superiorly, the inguinal ligaments and symphysis pubis inferiorly, and the anterior axillary lines laterally are entered into the protocol.. The patients are placed into one of two groups:

(1) those with clear evidence of peritoneal penetration (i.e., evisceration, free intraperitoneal air on

chest or abdominal radiography, or clinical findings of an acute abdomen) undergo laparotomy. After induction of general anesthesia and placement of a nasogastric tube and Foley catheter, diagnostic peritoneal lavage (DPL) is performed. The DPL technique is described below.

(2) those with no clear evidence of peritoneal penetration undergo local wound exploration in the ED. If the posterior rectus sheath has not been violated, the patient is discharged home after local wound care. If penetration is confirmed or cannot be excluded, the patient is taken to the OR for DPL and laparotomy as in the first group.

Lavage is not performed until the decision to perform laparotomy has been made. We define DPL as consisting of both aspiration via the lavage catheter and infusion of one liter of normal saline that is subsequently siphoned from the abdomen. A "grossly positive" lavage equates to aspiration of 10 cc of blood prior to instillation of the saline. The technique utilized for DPL is left to the discretion of the operating surgeon. The method used in all five of the present cases, however, was the "modified closed" technique. With this approach, the patient's abdomen is prepped and draped and the infraumbilical skin is locally anesthetized with 1% lidocaine with 1:1,000 epinephrine. A #11 scalpel blade is first used to make a 1-cm incision in the skin 2 or 3 cm below the umbilicus, and then to make a nick in the anterior fascia. A peritoneal lavage catheter is introduced over a trocar through the incision and into the peritoneal cavity, directed towards the pelvis. Aspiration and, if appropriate, lavage is then carried out. Effluent is sent to the laboratory for red and white blood cell counts, Gram's stain, and levels of amylase, total bilirubin, alkaline phosphatase, and lactate dehydrogenase. Lavage results are subsequently compared with finding at laparotomy.

CASE REPORTS

Case 1

A 33-year-old male presented to the ED four hours after he sustained a stab wound to the right lower quadrant (RLQ), 2 cm below and 2 cm lateral to the umbilicus. On arrival to the ED his vital signs were: pulse, 77/minute; blood pressure, 110/70 mm Hg; and respirations, 20/minute. There was no active external bleeding. There was a second stab wound to the patient's right thigh, which was also not bleeding and was felt to be superficial.

The patient's abdomen was soft and flat; there was moderate direct tenderness in the RLQ without peritoneal findings. Stool was heme-negative. Initial hematocrit was 47.1%; serum chemistries and urinalysis were normal. Blood ethanol level was 210 mg/dl. A nasogastric tube (NGT) and Foley catheter were inserted and the abdominal wound was locally explored after infiltrating the wound with 1% lidocaine with epinephrine. The wound clearly penetrated the deep fascia. The patient was taken to the operating room (OR) where after induction of general anesthesia, DPL was grossly positive.

Exploratory laparotomy through a midline incision was performed, with findings of a collection of 150-200 cc of blood in the pelvis. No intraabdominal injury could be identified upon close examination of the stomach, small bowel, colon, liver, spleen, and mesentery. From within, peritoneal penetration of the stab wound was confirmed. It was assumed that the bleeding had pooled in the pelvis from the wound in the abdominal wall. The surgical wound was closed and the patient subsequently did well. He was discharged without complications on the third postoperative day.

Case 2

A 39-year-old obese male presented to the ED shortly after he stabbed himself in the abdomen with a butcher knife. When the patient arrived the knife was impaled up to the handle, in the midline just below the umbilicus. Vital signs were pulse, 100/minute; blood pressure, 136/94 mm Hg; and respirations, 20/minute. There was no active external bleeding.

The patient's abdomen was mildly distended; bowel sounds were decreased. Initial hematocrit was 43% serum chemistries and urinalysis were normal. Blood ethanol level was 266 mg/dl. The patient was taken to the OR where after induction of general anesthesia and placement of Foley catheter and NGT he underwent DPL which was grossly positive.

The knife was removed and exploratory laparotomy through a midline incision was performed, with findings of approximately 200 cc of blood in the pelvis. No intraabdominal injury could be identified. The surgical wound was closed and the patient subsequently did well. He was transferred to the psychiatry service on the fourth postoperative day and was discharged home one week later without complications.

Case 3

A 43-year-old female presented to

the ED thirty minutes after she sustained a single stab wound to the right upper quadrant (RUQ), through which a loop of small bowel had eviscerated. The exposed bowel appeared uninjured, and there was no external bleeding from the wound. Vital signs in the ED were pulse, 98/minute; blood pressure, 130/70 mm Hg: and respirations, 20/minute. An NGT and Foley catheter were inserted.

The patient's abdomen was soft and flat; there was significant voluntary guarding and tenderness in the RUQ, but no rebound tenderness. Rectal examination yielded heme-negative stool. Initial hematocrit was 32%, serum chemistries were normal, urine pregnancy test was negative, and blood ethanol level was 55 mg/dl. The patient was taken to the OR where after induction of general anesthesia she underwent "modified closed" midline infraumbilical DPL. Aspiration through the lavage catheter returned > 10 cc of unclotted blood.

Exploratory laparotomy through a midline incision was performed, with findings of a nonbleeding grade I liver laceration and eviscerated, uninjured ileum. No other injury was identified. The liver laceration did not require repair. Postoperatively the patient developed deep venous thrombosis of the right lower extremity, complicated by pulmonary thromboembolism. She fully recovered and was discharged home on the eleventh postoperative day.

Case 4

A 23-year-old male presented to the ED one hour after he sustained a self-inflicted knife stab wound to the abdomen. The wound was in the midline, 5 cm above the umbilicus. Vital signs were pulse, 74/minute; blood pressure, 120/74 mm Hg; and respirations, 18/minute.

The patient's abdomen was soft and flat; there was no rebound tenderness, but the patient complained of left flank pain. Rectal examination yielded heme-negative stool. Initial hematocrit was 50.9%, and serum chemistries and urinalysis were normal. An NGT and Foley catheter were inserted. Abdominal and chest radiographs revealed no free intraperitoneal air. Local wound exploration revealed apparent peritoneal penetration. In the OR, DPL was grossly positive.

Exploratory laparotomy through a midline incision was performed, with finding of 250 cc of intraperitoneal blood. No intraabdominal injury could be identified, however, upon close examination of the stomach, small bowel, colon, liver, spleen, and mesentery. From within, peritoneal penetration of the stab wound was confirmed. It was assumed that the bleeding had collected in the pelvis from the abdominal wall. The surgical wound was closed and the patient subsequently did well. He was discharged without complications on the third postoperative day.

Case 5

A 24-year-old female presented to the ED three hours after she sustained a single stab wound to the RUQ, just below the right costal margin. Vital signs in the ED were pulse, 98/minute; blood pressure, 110/70 mg Hg; and respirations, 18/minute.

The patient's abdomen was soft and flat; she was tender only in the area around the stab wound. There was no active external bleeding or evisceration. Rectal examination yielded heme-negative stool. Initial hematocrit was 33.6%, serum chemistries were normal, urine pregnancy test was negative, and the blood ethanol level was 110 mg/dl. Local wound exploration confirmed peritoneal penetration. An NGT and Foley catheter were inserted, and lavage catheter aspiration yielded 10 cc of unclotted blood.

Exploratory laparotomy through a midline incision was performed, with findings of a small nonbleeding laceration in the liver capsule that did not require repair. No other intraabdominal injury was identified, but there was continuing venous oozing from the internal aspect of the stab wound. The patient tolerated the surgery well and was discharged without complications on the fourth postoperative day.

DISCUSSION

Abdominal paracentesis for the detection of hemoperitoneum after blunt abdominal trauma was first reported by Neuof and Cohen in 1926.[1] Diagnostic peritoneal lavage (DPL) was subsequently described for use in blunt trauma victims by Root and coworkers in 1965.[2] As adjuncts to physical examinations, DPL and computed tomography of the abdomen currently comprise the standard of care in evaluation of blunt force injuries.[3] The use of DPL in the evaluation of penetrating abdominal trauma, however, has been less well received. Because of differences in mechanism of injury, victims of abdominal gunshot wounds (GSWs) and stab wounds are generally considered separately, since GSWs nearly always require laparotomy.[4]

Over the years the evaluation of abdominal stab wounds (ASWs) has gradually evolved to a more selective approach in an attempt

to reduce the number of unnecessary exploratory laparotomies, while still minimizing the morbidity and mortality of delayed operative intervention. Such "selective conservatism" was first proposed 30 years ago.[5] The basis for decisions in the selective management of ASWs has ranged from wound sinography[6] to serial physical examinations[7-14] to local wound exploration combined with DPL.[3,4,11,15-18] We initiated the present study in order to characterize further the predictive power of DPL for therapeutic laparotomy in ASW.

In the five patients presently reported, aspiration was positive for blood through a "modified closed" lavage technique. In our experience with blunt trauma victims, this technique has rarely yielded false positive results. Examination of the lavage sites at laparotomy in all five cases excluded iatrogenic injury that could have resulted in positive aspirations. In all cases, intraabdominal blood resulted from abdominal wall bleeding, minor liver lacerations, or both.

The association of a grossly positive lavage with nontherapeutic laparotomy has been previously reported, but with a low incidence. To date we have encountered three other positive aspirations in our protocol; all were associated with operable intraabdominal injuries at laparotomy. Henneman et al[3] reported a positive predictive value of 91% for grossly positive lavages in penetrating abdominal trauma; they noted four false-positive aspirations (FPAs)--i.e., accurate detection of hemoperitoneum, but followed by nontherapeutic laparotomy--resulting from Grade I liver lacerations. In contrast, retrospective data presented last year from Cook County Hospital revealed 100% true-positive aspirations (TPAs)--i.e., laparotomy was therapeutic after grossly positive tap--among 50 ASW victims.[19]

Swann and colleagues[20] reported one TPA and no FPAs among 20 patients undergoing laparotomy for ASW. Three earlier studies have reported nontherapeutic laparotomies after ASW with positive DPL (grossly positive vs. cell count criteria not specified) in a total of 11 of 446 patients (2.5%). All were attributed to excessive bleeding into the peritoneal cavity from the stab wound site in the abdominal wall.[15,17,21] Feliciano at el[18] reported 148 grossly positive lavages in ASW: 129 were TPAs. The 19 FPAs (12.8%) were all felt to be the result of abdominal wall bleeding.

From among 590 ASW patients, McAlvanah and Shaftan[9] reported six FPAs deemed secondary to abdominal wall bleeding, three FPAs probably secondary to self-limited liver injuries, and two FPAs in patients whose stab wounds were found at laparotomy not to have penetrated the peritoneum. These final two cases must be ascribed to the lavage itself.

Demetriades and Rabinowitz,[13] meanwhile, reported 12 patients with "abdominal paracentesis positive for blood," all with ASWs over the liver, who were managed without surgery and had no complications. Although an explanation was not offered, it is apparent that they felt the majority of these FPAs resulted from minor hepatic injuries; abdominal wall bleeding may also have contributed. These authors also reported a separate series of penetrating liver injuries, one-third of which were managed nonoperatively.[22]

In retrospect, at least three of the five cases in the present study could have been managed nonoperatively. Case 2, with a retained knife, may have mandated laparotomy although this point could be debated. Evisceration, as in Case 3, is likewise usually managed by exploration[23,24] although some surgeons have advocated reduction of small eviscerations in the ED.[11,13,25] Nevertheless, despite unimpressive clinical presentations, stab wound patients with grossly positive lavages usually undergo laparotomy--a decision that is probably influenced by the data on DPL in blunt abdominal trauma. The reemergence of interest in laparoscopy for evaluation of ASW, which can be performed in the ED, may contribute to greater success in the nonoperative management of these injuries.[26]

SUMMARY

The concept of selective management for ASWs is standing the test of time. The most successful protocols reported to date include the use of DPL.[3,4,11,15-18] There is a potential, however, for misleading results from this procedure when there has been bleeding from the internal aspect of the stab injury to the abdominal wall. Physicians caring for trauma patients should be cognizant of this potential when considering the need for laparotomy after abdominal stab wound. We suggest that the results of DPL in the evaluation of ASWs be interpreted in light of other clinical findings and the overall condition of the patient, and perhaps should not be employed as an absolute indication for operative management. ❑

2345 East Thomas, Suite 310
Phoenix, AZ 85016

REFERENCES

1. Neuof H, Cohen I. Abdominal puncture in the diagnosis of acute

intraperitoneal disease. *Ann Surg* 1926;83:454-462.
2. Root HD, Hauser CW, McKinley CR, LaFave JW, Mendiola RP. Diagnostic peritoneal lavage. *Surgery* 1965;57:633-637.
3. Henneman PL, Marx JA, Moore EE, Cantrill SV, Ammons LA. Diagnostic peritoneal lavage: Accuracy in predicting necessary laparotomy following blunt and penetrating trauma. *J Trauma* 1990;30:1345-1355.
4. Thompson JS, Moore EE, Van Duzer-Moore S, Moore JB, Galloway AC: The evolution of abdominal stab wound management. *J Trauma* 1980;20:478-484.
5. Shaftan GW. Indications for operation in abdominal trauma. *Am J Surg* 1960;99:657-664.
6. Aragon GE, Eisman B. Abdominal stab wounds: Evaluation of sinography. *J Trauma* 1976;16:792-797.
7. Rothschild PD, Treiman RL. Selective management of abdominal stab wounds. *Am J Surg* 1966;111:382-287.
8. Printen KJ, Freeark RJ, Shoemaker WC. Conservative management of penetrating abdominal wounds. *Arch Surg* 1968;96:899-901.
9. McAlvanah MJ, Shaftan GW. Selective conservatism in penetrating abdominal wounds. A continuing appraisal. *J Trauma* 1978;18:206-212.
10. Wilder JR, Kudchadkar A. Stab wounds of the abdomen. *JAMA* 1980;243:2503-2505.
11. Demetriades D, Rabinowitz B. Selective conservative management of penetrating abdominal wounds. A prospective study. *Br J Surg* 1984;71:92-94.
12. Lee WC, Uddo JF, Nance FC. Surgical judgment in the management of abdominal stab wounds: Utilizing clinical criteria from a 10-year experience. *Ann Surg* 1984;199:549-554.
13. Demetriades D, Rabinowitz B. Indications for operation in abdominal stab wounds: A prospective study of 651 patients. *Ann Surg* 1987;205:129-132.
14. Zubowski R, Nallathambli M, Ivatury R, Stahl W: Selective conservatism in abdominal stab wounds: The efficacy of serial physical examination. *J Trauma* 1988;28:1665-1668.
15. Thal ER. Evaluation of peritoneal lavage and local exploration in lower chest and abdominal stab wounds. *J Trauma* 1977;17:642-650.
16. Galbraith TA, Oreskovich MR, Heimbach DM, Herman CM, Carrico CJ. The role of peritoneal lavage in the management of stab wounds to the abdomen. *Am J Surg* 1980;140:60-64.
17. Oreskovich MR, Carrico CJ. Stab wounds of the anterior abdomen: Analysis of a management plan using local wound exploration and quantitative peritoneal lavage. *Ann Surg* 1983;198:411-419.
18. Feliciano DV, Bitondo CG, Steed G, Mattox KL, Burch JM, Jordan GL: Five hundred open taps or lavages in patients with abdominal stab wounds. *Am J Surg* 1984;148:772-777.
19. Sloan EP, Gelman VR, Shabowski S, Barrett JA. The role of mandatory laparotomy in patients with a positive peritoneal tap. Presented at Scientific Forum, Rocky Mountain Conference on Emergency Medicine and Nursing, Crested Butte, Colorado, January, 1991.
20. Swann IJ, Allister CA, Lewi HJ, Watt I, Finlay IG. The value of peritoneal lavage in the assessment of patients with stab wounds of the abdomen and lower chest. *J Roy Coll Surg Edin* 1986;31:40-43.
21. Thal ER. Peritoneal lavage: Reliability of RBC count in patients with stab wounds to the chest. *Arch Surg* 1984;119:579-584.
22. Demetriades D, Rabinowitz B, Sofianos C. Non-operative management of penetrating liver injuries: A prospective study. *Br J Surg* 1986;73:736-737.
23. Medina M, Ivatury RR, Stahl WM. Omental evisceration through an abdominal stab wound: Is exploratory laparotomy mandatory? *Can J Surg* 1984;27:399-401.
24. Burnweit CA, Thal ER. Significance of omental evisceration in abdominal stab wounds. *Am J Surg* 1986;152:670-673.
25. Huizinga WKJ, Baker LW, Mitshail ZW. Selective management of abdominal and thoracic stab wounds with established peritoneal penetration: The eviscerated omentum. *Am J Surg* 1987;153:564-568.
26. Berci G, Sackier JM, Paz-Partlow M. Emergency laparoscopy. *Am J Surg* 1991;161:332-335.

Drs. Pollack and **Jorden** are with the Department of Emergency Medicine, Maricopa Medical Center, Phoenix, AZ. **Dr. Poole** is from Trauma and Critical Care Surgery, University of Mississippi Medical Center, Jackson, MS and **Dr. Griswold** is with the Department of Surgery, Texas Tech University Health Sciences Center, Lubbock, TX.

All the above physicians were with the Department of Surgery, University of Mississippi Medical Center, Jackson, Mississippi when this paper was written. It was presented at the 1991 annual meeting, Emergency Medicine Section, Southern Medical Association, where it received the award for best scientific presention by a resident.



Photo courtesy of the Mississippi Department of Economic and Community Development.

Placid. Peaceful. Protected.

Putting your mind at ease so you can concentrate on providing the best health care for your patients. As the nation's largest doctor-owned, doctor-managed professional liability insurer, The Doctors' Company works with over 16,300 member physicians, helping them reduce losses and improve patient care.

We're here to protect the professional environment of Mississippi physicians. The Doctors' Company is helping good doctors practice better medicine.

If you're not already a member, call The Doctors' Company today.

(800) 898-0373

THE DOCTORS' COMPANY

The Doctor-Owned. Doctor-Managed Professional Liability Specialists.

Represented in Mississippi by: Sampson Howard & Ashcraft
Bill Howard
(800) 530-7598 (National) • (601) 956-3720

Evaluation of Mammographic Calcification

W. MEL. FLOWERS, JR., MD
DONNA S. LAUNEY, MD

Breast cancer is the leading cause of cancer death among women. In 1961, a woman had a 1 in 20 chance of developing breast cancer during her lifetime. This risk has risen to approximately 1 in 9. The cause of breast cancer is not known, and prevention must await further research. Breast self-examinations, regular physical examinations, and mammograms are early detection methods that save lives and should be encouraged. Although the mammogram is imperfect, it is the most effective means of detecting breast cancer available to us today.

There are several different radiographic signs that alert the radiologist that there may be a significant problem. These include a stellate mass, a circumscribed mass, skin thickening, nipple retraction, a newly developing density, ductal dilatation, architectural distortion, and abnormal calcifications. The present discussion will be limited to the analysis of abnormal calcifications.

ANALYSIS OF BREAST CALCIFICATIONS

Breast calcifications can be focal or diffuse. Analysis of these calcifications should take into account not only their distribution but also their form, size, number, and density. It is important to localize calcifications to the anatomical site of origin. For example, lobular calcifications occur in cyst like dilated lobules. Ductal calcifications occur in terminal ducts and ductules. Miscellaneous calcifications occur in arterial walls, fibroadenomas, oil cysts, and papillomas. The goal is to determine the pathological process that produced the calcifications. The majority tend to assume the shape of the structure or cavity into which they are formed. Therefore, determining the anatomical site and pathological process can be highly successful. Whether calcifications present with or without mass is another key feature in determining the underlying diagnosis.

MALIGNANT CALCIFICATIONS

Malignant type calcifications originate in the terminal ducts and ductules either from active cellular secretion or from calcifications of intraluminal cellular debris. They are of two basic forms: casting and granular.

Casting calcifications represent casts of segments of the ductal lumen, sometimes filling in a branch of the duct. Carcinoma invading a duct produces an irregular contour; and therefore the calcified casts differ in their length and density. These can be differentiated from the intraductal type of calcifications seen with plasma cell mastitis which appear regular in form and outline and have an uniform density.

Granular type calcifications are extremely variable in form, size, density, and number. They are said to resemble very fine grains of salt or crushed stones. The highly irregular ductal proliferation that produces them accounts for their individual irregularity. Intraductal malignant type calcifications are frequently clustered into an area of the breast measuring approximately 1 cubic centimeter or less. The size of the individual calcifications is limited originally by the size of the lumen of the duct al-



Figure 1 - *Malignant calcifications.* *Focal microcalcifications, highly suspicious for malignancy. Biopsy revealed carcinoma.*



Figure 2 - *Indeterminate calcifications.* *Clustered microcalcifications, moderately suspicious for malignancy. Biopsy revealed intraductal calcifications and fibrocystic disease. No carcinoma found.*

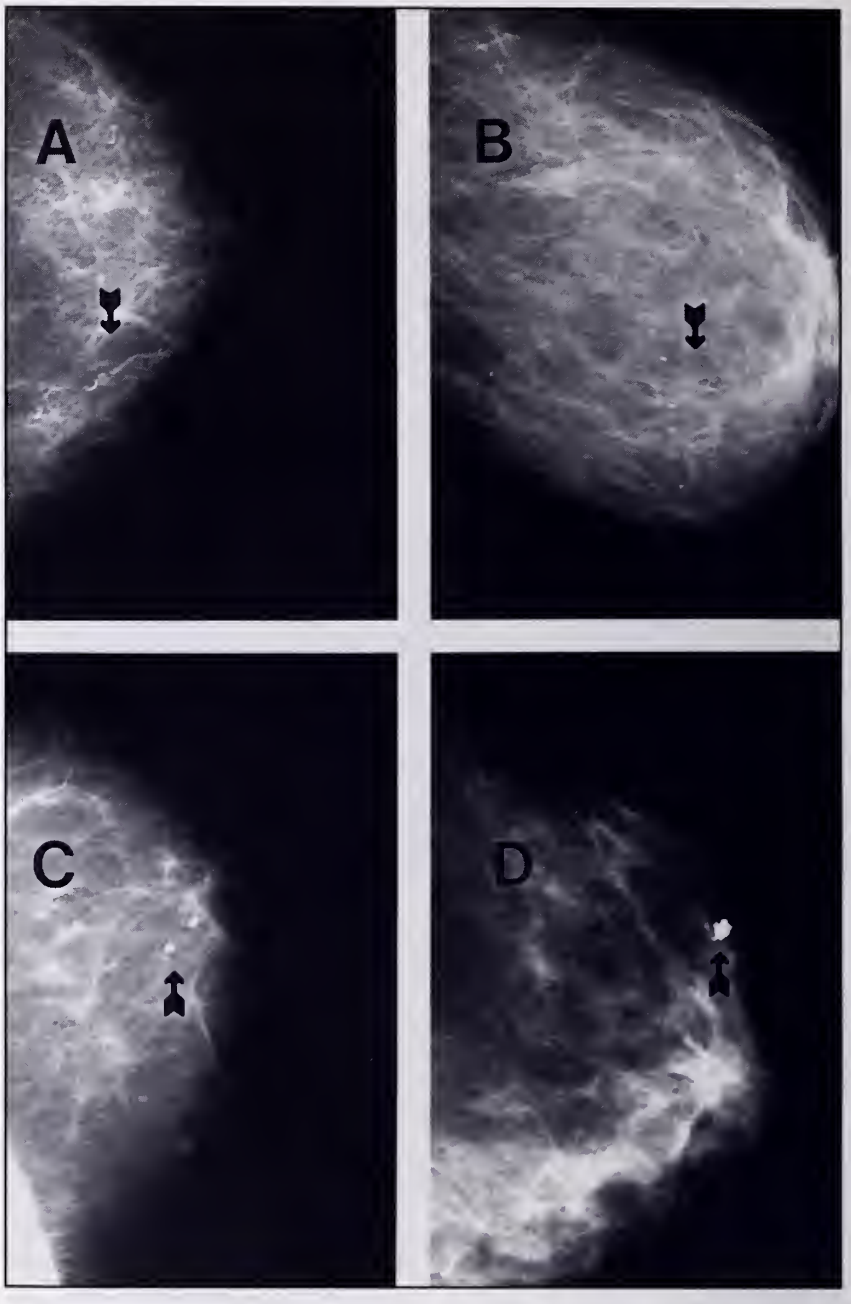


Figure 3 - *Benign calcifications.*
A: Arterial wall calcifications.
B: Secretory calcifications.
C: Calcified oil cysts.
D: Calcification in a hyalinizing fibroadenoma.

though later it may become larger through coalescence or tissue necrosis. Individual calcifications tend to vary in density with each other and within the particle itself. Individual particles of malignant type calcifications are very small. Many are so small that they are properly evaluated only with magnification radiography or a good magnifying glass. The number detected is highly dependent on the radiographic technique and whether or not magnification is used. The actual number of calcifications is not as important as the other features.

In summary, malignant calcifications tend to be very small, and heterogenous in appearance. They rarely have a rounded or smooth contour.

OTHER TYPES OF CALCIFICATIONS

There are several types of calcifications that have characteristic morphology. They do not cause concern for the presence of malignancy. Examples include the double track appearance seen with calcified arterial walls, and the smooth outline and high density calcifications seen with plasma cell mastitis. Some benign calcifications can be shown to lie within the skin. Coarse, lobulated calcifications seen within fibroadenomas and "egg-shell" calcifications seen with fat necrosis are also benign processes. Secretory deposits are continuous linear rods that conform to the shape of the duct. Milk of calcium microcystic calcifications are due to precipitation of calcium within dilated acini or lobules. These typically have a "teacup" appearance, with the calcium forming a crescent on the oblique mediolateral view and a smudged dot on the craniocaudal view.

SUMMARY

Breast calcifications can be classified into ductal, lobular, or miscellaneous types. Analysis is less difficult using this classification. Frequently, the characterization of miscellaneous types is straightforward.

The analysis of ductal type and lobular type microcalcifications is more challenging. If they are scattered, the most important determination is whether or not there are casting calcifications present. If so, malignancy cannot be excluded. If clustered, then analysis of their form becomes critical. Teacup or pearl type calcifications are benign. Granular or casting calcifications are malignant. Mammographic calcifications that appear obviously malignant or highly suspicious for malignancy warrant biopsy whether or not a mass is clinically palpable. If calcifications are obviously benign, then routine follow-up at four to six month intervals if there is a high probability that they are benign. Otherwise, they are biopsied at the discretion of the clinician. ❑

2500 North State Street
Jackson, Mississippi 39216-4505

Dr. Flowers is associate professor of Radiology and Dr. Launey is a Radiology Resident at the University of Mississippi Medical Center.



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

A singer. A board-certified family practitioner. Soft-spoken for a New Yorker. Ron Richmond knows...

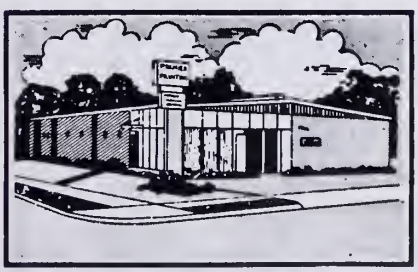
It's a great way to practice medicine

CompHealth
LOCUM TENENS

1-800-453-3030
Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol **Jackson, Mississippi**

Phone 352-4091

THE UNITED STATES ARMY RESERVE
HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM
$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

Mississippi State Board of Medical Licensure Annual Report July 1, 1990 through June 30, 1991

FRANK J. MORGAN, JR., MD

The Mississippi State Board of Medical Licensure is the State's legally constituted licensure Board for physicians (M.D.), osteopathic physicians (D.O.), and podiatrists (D.P.M.). The Board, which meets bimonthly on the third Thursday beginning in January of each year, is composed of nine physicians appointed to staggered terms by the Governor.

The Board is responsible for setting policies and professional standards regarding the practice of physicians (M.D.), osteopathic physicians (D.O.), and podiatrists (D.P.M); considering applications for licensure; conducting examinations for licensure; investigating legitimate drug traffic among medical practitioners under the Uniform Controlled Substances Act; conducting investigations in disciplinary matters involving violations of state and federal laws; probation, suspension and revocation of licenses; considering petitions for terminations of probationary and suspension periods and restoration of revoked licenses; promulgating reasonable rules and regulations necessary to enable it to discharge its functions; and enforcing the provisions of the law regulating the practice of medicine.

The administrative functions of the Board are performed under the direction of its Executive Officer, Frank J. Morgan, Jr., MD, by eleven full-time staff members, including five investigators; an administrative assistant; a licensing officer; an accountant, and two secretaries. The office of the Board is located at 2688-D Insurance Center Drive, Jackson, Mississippi 39216.

LICENSURE

Any physician, osteopathic physician, or podiatrist desiring to practice medicine in Mississippi must first obtain a license to do so by contacting the Board. When an inquiry concerning licensure is received, a questionnaire to elicit certain pertinent information is sent to the practitioner. Based upon the information given by the practitioner, a determination is made as to the type of license for which he is eligible. Names of references submitted on questionnaire, as well as the American Medical, Osteopathic, or Podiatric Medical Associations, other states in which the practitioner has been licensed, and hospitals where the practitioner has held staff privileges are sent inquiries. If the information received is favorable, and application is sent to the physician.

RECIPROCITY/ENDORSEMENT

The Board of Medical Licensure may grant licenses to practice medicine without examination as to learning, to graduates in medicine, osteopathic medicine, or podiatry who hold licenses to practice from other states, provided the requirements in such

states are equal to those set forth by this Board. In addition, this Board may affiliate with and recognize for the purpose of waiving examination, diplomates of the National Board Medical Examiners, the National Board of Osteopathic Medical Examiners and the National Board of Podiatry Examiners in granting licenses to practice in Mississippi.

During FY91, 55 practitioners requested applications for licensure by reciprocity with other states or through endorsement of the examinations given by the National Board of Medical, Osteopathic, and Podiatric Examiners. Based upon these request, 235 applications were processed and approximately 6672 reference inquiries were made by the Office of Medical Licensure to determine the eligibility of applicants for a license to practice in Mississippi.

Following receipt of favorable certificates of training and personal interviews, a total of 338 physicians, 7 osteopathic physicians and 7 podiatrists were licensed in Mississippi.

In addition, 18 temporary medical licenses which allowed applicants 30 days in which to complete the necessary requirements for permanent licensure were issued.

Effective July 1, 1982, an amendment to the Medical Practice Act permitted the issuance of temporary licenses to non-resident and retired resident physicians to practice for up to 90 days in licensed youth camps in Mississippi. Nine (9) such licenses were issued during FY91.

EXAMINATION

The nationally administered Federation Licensing Examination (FLEX) was adopted as the state's medical licensing examination in 1973. The three-day FLEX is a written objective-type, comprehensive examination which tests applicants in the basic sciences, clinical sciences and clinical competence. Component I is designed to evaluate measurable aspects of knowledge and understanding of basic and clinical science. Component II focuses on critical abilities and knowledge required for diagnosis and management of selected ambulatory and in-patient clinical problems representing a core of clinical situations frequently encountered by the physician licensed for the independent practice of medicine. A score of 75 is required on each component for passing. The FLEX is given in June and December of each year, and the dates are set by the FLEX Board of the Federation of State Medical Boards of the United States, of which this Board is a member.

Applicants for licensure by examination are screened in the same way as those seeking licensure by reciprocity. References are obtained and credentials are checked thoroughly. During FY91, 101 applicants were declared eligible and took the examination. Ninety-seven passed both components. Those applicants who were successful will be granted licensure upon their submitting documentation of completion of one year of accredited postgraduate training.

Beginning in the Spring of 1988, SPEX (Special Purpose Examination) was offered as a quarterly administration: March, June, September, and December. The June and December SPEX administrations are set to coincide with the last day of the respective three-day FLEX administration.

This one-day examination is administered to applicants who possess all the qualifications for licensure by reciprocity/endorsement, with the exception of having successfully passed a written medical competency examination within a 10-year period prior to filing his/her application.

The FY91, five (5) candidates made application and took SPEX. All were successful.

The office of Medical Licensure obtained documentation of completion of postgraduate training in behalf of 93 physicians who passed the June and December 1989 and June, 1990 FLEX examination, and medical licenses were issued to them.

A total of 43 restricted temporary licenses were issued for the period July 1, 1990 through June 30, 1991, to applicants for licensure who entered their first year of postgraduate training at the University of Mississippi Medical Center, Jackson. The temporary licenses permitted them to practice only within the scope of their respective residency training programs at the University.

LIMITED INSTITUTIONAL LICENSURE

In addition to licensure by examination and reciprocity, state law also provides for limited institutional licensure which is available only to graduates of foreign medical schools for their employment in state-supported institutions. It was the intent of the law to enable Mississippi institutions to utilize the services of qualified foreign medical graduates during the period necessary for them to meet the requirement for permanent licensure.

Based upon their presenting to

the Office of Medical Licensure their original medical diplomas, documentation of certificates from the Educational Commission for Foreign Medical Graduates (ECFMG), Visa Qualifying Examination (VQE), or Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), and favorable references, 9 applicants were issued limited institutional licenses to practice in state-supported institutions. In addition, 20 limited institutional licenses were renewed during this period.

Since limited institutional licensure was established in 1971, 369 such license have been issued. As of June 30, 1991, a total of 10 of the limited institutional licensees have met all requirements, including passing the FLEX and fulfilling the post-graduate training requirements, and have been issued permanent medical licenses in Mississippi.

CERTIFICATION AND VERIFICATION

A practitioner originally licensed in Mississippi by examination who seeks licensure in another state through reciprocity must have his license in this State and the scores he obtained on the licensure examination certified by this Board to the reciprocating state. 470 such certifications were made by the Office of Medical Licensure during FY91 and 139 letters of good standing were completed.

The Board also verified the licensure status of practitioners to health care providers, health insurance carriers, licensing boards of other states, and state and federal law enforcement and regulatory agencies.

Approximately **6,000** verifications of licensure were made by this Board during FY91.

ANNUAL RENEWAL

The license of every physician, osteopathic physician, and podiatrist licensed to practice in the state must be renewed annually. On or before May 1, of each year, an application for renewal of license is mailed to all practitioners licensed by this Board to practice in Mississippi. The applications must be completed and returned to the Board along with the renewal fee by June 30.

Based upon information given on the renewal applications, as of July 1, 1990, there were **5,792** physicians licensed to practice in medicine in Mississippi. Of this number **3,378** resided and practiced in state and **2,131** resided out of state.

A total of **1,652** in-state physicians worked in the primary care specialties, which include family practice, general practice, internal medicine, pediatrics, and obstetrics and gynecology.

As of June 30, 1991, **5,909** practitioners had renewed for the period July 1, 1991 through June 30, 1992. **3,624** practice and reside in Mississippi and **2,275** reside out of state, but elected to maintain current licensure in Mississippi.

INVESTIGATIONS

Under the direction of the Executive Officer, the Board's five investigators carried out the responsibilities of investigating alleged violations of the Medical Practice Act and the Mississippi Uniform Controlled Substances Act as it applies to medical practitioners. During the fiscal year the Board received **246** complaints regarding alleged violations from various sources including state and federal law enforcement officials, state and federal regulatory agencies, hospital administrators, local and state medical societies, medical licensing boards of other states, health professionals and lay individuals. A total of **121** practitioners or individuals were investigated by the Medical Board investigative staff. In conducting these investigations and inspections a total of **569** pharmacies were profiled throughout the State of Mississippi. Analysis of the **121** investigations revealed **84** practitioners were investigated for suspicious or excessive prescribing of controlled substances; **1** involved personal abuse of alcohol; **1** involved improper or unnecessary surgery; **11** involved failing to keep records of substances dispensed/prescribed; **2** involved personal use of or addiction to drugs; **8** involved other narcotic violations; **1** involved incompetence; **3** investigations involved unprofessional conduct; **3** involved the illegal practice of medicine; **1** was due to violation of probations; **3** involved lewd conduct; **2** follow-up compliance investigations were made; **1** involved intentionally or unlawfully dispensing drugs. Of the **84** investigations involving suspicious or excessive prescribing patterns, **29** of these practitioners were written letters by the Executive Officer warning them against future violation of federal and state laws regarding prescribing of controlled substances. Additionally, **85** urine screens were collected and **13** audits of drugs handled by dispensing physicians were accomplished.

As a result of the investigations **8** practitioners voluntarily surrendered their privileges (DEA

Certificates) authorizing them to handle controlled substances. Four (4) of these surrenders involved physicians who were personally abusing controlled substances; **1** involved unprofessional conduct; and **3** involved excessive prescribing.

DISCIPLINARY ACTIONS

Additionally, investigations conducted by the Board resulted in **10** disciplinary hearings. Following consideration of these matters, **5** licenses were revoked; **2** medical licenses by reciprocity were denied; **1** license was revoked, revocation stayed and license placed on probation; and **2** voluntary surrenders of medical licenses were accepted.

Petitions for removal of restrictions were considered on **7** medical licenses. Of these, the Board denied **3** and granted **4**.

Four (**4**) physicians requested reinstatement of their medical licenses. Two (**2**) were denied and **2** were granted.

In other actions, the Board granted **1** license by reciprocity and approved **3** plans of practice. Four (**4**) requests for waivers on limited institutional license were denied.

Seven (**7**) physicians had their controlled substances prescribing privileges restored and **1** physician was denied permission to reregister with the Drug Enforcement Administration for prescribing privileges.

Entering into Consent Agreements with **14** physicians, the Board revoked **1** license, stayed the revocation and placed on probation; issued **1** letter of precautionary warning; suspended **3** licenses, stayed the suspensions and placed licenses on probation; accepted **1** voluntary surrender of medical license; placed **2** licenses on probation and restricted **6** medical licenses.

Amendments to the Regulations Governing the Practice of Physicians (M.D.), Osteopathic Physicians (D.O.), and Podiatrists (D.P.M) were adopted by the Board during fiscal year 1991. They include:

(1) Regulations Pertaining to Prescribing, Administration and Dispensing of Medication. Each physician throughout the state received a copy of this "Red Book."

(2) Regulations Pertaining to Release of Medical Records.

In September, 1990, as mandated by Public Law 99-660, the Board began reporting all disciplinary actions to the National Practitioners Data Bank and Malpractice Insurance carriers were required to report all paid malpractice claims to this Board.

The Board further published its first "Newsletter" in the Spring of 1991. This publication is distributed to all licensees; other in-state health care boards and associations; hospitals; other state licensing boards; it is available also to any person who request a copy. The newsletter will serve to inform licensees of pertinent Board functions and activities. The Board will publish the newsletter bi-annually.

The following is the current Board membership as of June 30, 1991:

Matthew J. Page, MD
Secretary
1659 East Union Street
Greenville, MS 38701
Term: 7/1/86 - 6/30/92

T. Steve Parvin, MD
105 Doctors Park
Starkville, MS 39759
Term: 7/1/88 - 6/30/92

Richard F. Riley, MD
2111 14th Street
Meridian, MS 39301
Term: 7/1/88 - 6/30/92

Billy Wayne Long, MD
1421 North State Street,
Suite 203
Jackson, MS 39202
Term: 7/1/89 - 6/30/94

John Purves McLaurin Jr., MD
2200 S. Lamar Boulevard,
Suite C
Oxford, MD 38655
Term: 7/1/89 - 7/1/94

W. W. Walley, MD
President
904 Mississippi Drive
Waynesboro, MS 39367
Term: 7/1/88 - 7/1/94

Joseph Rudolph Mitchell, MD
4333 15th Street, Suite A
Gulfport, MS 39501
Term: 7/1/90 - 7/1/96

John Langan Pendergrass, MD
PO Box 15729
Hattiesburg, MS 39404
Term: 7/1/90 - 7/1/96

Walter H. Rose, MD,
Vice President
122 E. Baker Street
Indianola, MS 38751
Term: 7/1/90 - 3/30/96 ❑



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

A Risk Retention Group



The President's Page

WILLIAM C. GATES, MD

President of the Medical Society Syndrome "PMS-S"

What is it about being elevated to the position of President of the Medical Society (PMS) that causes the President of the Medical Society Syndrome (PMS-S)? I don't know...

PMS-S is characterized by the rather abrupt, sudden onset of omniscience and omnipotence and maybe even clairvoyance along with a touch of McCarthyism and some Chicken Little thrown in, too.

It's amazing how just moving those little black and white title boards around on the head table to put them in front of new people by itself seems to cause those breath-taking flashes of brilliance and such clarity of vision and purpose (even though the PMS is still swimming in the same stream of information and has definitely not had a visitation by the deity or stumbled over some new commandments etched in stone by lightning bolts).

What causes PMS-S? I don't know ... it's acquired, not congenital ... it jumps on the PMS like white on rice ... it can be major or minor or intermediate in severity, but every PMS has some ... it may be manifested by a truly blatant and very irritating symptom complex or it may be barely appreciable and notable only by its subtlety and the insidiousness hidden in the hue and tenor of certain carefully crafted statements and declarations.

It's conceivable that the PMS may not even be aware that he/she has PMS-S, even when it's in its florid, flagrant form. It's not a pretty sight.

Can PMS-S be cured? I don't know ... probably not ...

Do I have PMS-S? I don't know ... probably ...

I hope my note finds you and yours doing well ...

Best regards,
Bill

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 9
SEPTEMBER 1992

Behavior Modification

By most accounts, it appears that there will soon be significant, if not drastic, changes in the way health care is financed in the United States. It would be impractical in this forum to review the many plans which have been proposed by various interested parties, including organized medicine. All, however, include universal access as a cornerstone. One disturbing element in these various scenarios is the apparent lack of attention to the question of who will pay for the care of illnesses and injuries which are self inflicted as a result of unhealthy behavior. The question arises, should those citizens who adhere to healthy lifestyles be required to pay, through taxes, for the care of individuals who suffer illnesses or injuries which are direct result of a proven unhealthy behavior, such as tobacco use, or driving under the influence of alcohol?

The concept of rating individuals for insurance purposes based on past health history is not new, and is probably not fair for those illnesses or conditions over which the individual has no control. The concept of rating individuals based on self-injurious behavior is also not new, and seems ultimately fair, but has not been utilized previously to any great extent. It seems reasonable that physicians should strongly support this concept, as a matter of fairness as well as motivation toward healthier lifestyles, and also should insist on its incorporation into any universal health plan which might be implemented. If necessary, the medical community might take issues such as this directly to the voters by way of the mass media, explaining the issues in a very positive way, in order to help achieve the desired results. When educated regarding the facts, the people will usually make the right choices, and also insist that their elected representatives do likewise.

George E. Abraham, II, MD
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Letters

To the Editors *Journal MSMA:*

I read with interest the President's Letter in the recent July 1992 Journal and as usual, editors of our Journal, it is of the highest quality in that it speaks to the basic problems inherent in mankind.

Whether or not we can distinctly separate priests and philanthropists from pirates and profiteers is a difficult task with no easy solution. To draw a divisive line not knowing who is the wolf in sheep's clothing is part of the historical problem. This is not to be cynical or to insinuate that there are not solutions.

It was a pleasure also to see that our president did not offer us the usual advice that we get so often, "If you don't clean up your act, the government is going to clean it up", and other admonitions that have been for so long the byword of the profession so that it has become like a bell with no clacker. It is good to see that he does not suffer from the PMSMAS syndrome (President of Most State Medical Associations Syndrome).

PMSMAS is on occasion of insidious onset characterized by intracranial pressure (where actually the hat size does not increase) but the illusion of increased hat size is there. Also one may suffer from bloats (too many meals of beans, roasts and lemon pie that the president must endure on his various engagements), agitation of hemorrhoids (traveling too much, sitting too much) along with swelling of the feet (similar to PMS which we see in our gynecological patients) and there seems to be no definite cure. There are many treatments suggesting that the etiology of this aggregation of symptoms is difficult to ascertain and difficult to early diagnose and treat properly. However, it is self-limited and once the cycle is over the patients seem to do better until the next cycle.

Priests and philanthropists, pirates and profiteers are smooth alliterations but as one reviews the history of Judaism in I and II Samuel and I and II Kings of the King James version or other preferred translations of the Old Testament, one finds that the priests had forsaken their duties and therefore the people did not know is which direction to turn. The philanthropists were found to be for a great part those people who were philanthropic only after much ill gotten gain.

We can usually recognize the pirates and profiteers making it easy to, as Dr. Gates suggests, to "ferret out" those individuals. We all know a ferret is a half tame cousin to the common pole cat so I do not know who is going to do the ferreting. It would be nice and easy if we could infuse and transfuse into the pirates and profiteers the highest standards of the priests and philanthropists but it has never been so, is not so presently, and probably will not be so in the future. The few must carry the many. It is imperative, therefore, that the foundation be solid though the structure occasionally trembles.

I have always been impressed with the leadership of this particular state medical association and when one reviews our history, even prior to and especially including Dr. Underwood of the State Health Department, one finds that we have been blessed with men of great stature. Also it is good to dream and have visions but they must be enveloped in a coherent and enduring principle of truth and motive. As we all know, truth and motive are difficult to ferret out even from the priests and the philanthropists, the pirates or the profiteers.

Thank you very much for allowing me to respond and please accept this not as cynical criticism but simply to reiterate that fact that it is good to know that Dr. Gates does not suffer from PMSMAS and knowing him as I do, will not have it.

Respectfully yours,
Perrin N. Smith, MD
Columbus, Mississippi ◻



"Current Opinions"

of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON PRACTICE MATTERS

Gifts to Physicians From Industry

Many gifts given to physicians by companies in the pharmaceutical, device and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with principles of medical ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

(1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted.

(2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g., pens and notepads).

(3) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(4) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physician's time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging and other out-of-pocket expenses.

(5) Scholarship or other special funds to permit medical students, residents and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents or fellows who will receive the funds is made by the academic or training institution.

(6) No gifts should be accepted if there are stings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods and materials should belong to the organizers of the conference or lecture. ❑



MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE

The MSMA provides a toll free WATS for any member to call to inquire about programs and policies of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

LIAISON SERVICES

MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE

MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA Diversified Services, Inc.

BUSINESS AND PERSONAL INSURANCE

The MS Physicians Insurance Company (MPIC) through its managing general agency, Evans and Giordano, offers a wide range of low cost business and personal insurance for members of the association. MPIC has a Board of Directors appointed by MSMA composed entirely of practicing physicians who with the advise and assistance of Evans and Giordano seek to identify the special insurance needs of physicians. For further information call Evans and Giordano.

PRACTICE MANAGEMENT

Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE

Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call Robert Kidd at MSMA.

FINANCIAL/RETIREMENT PLANNING

MSMA members by virtue of their membership in the AMA are eligible to participate in AMA Investment Advisors, Inc. This wholly owned investment subsidiary of the AMA offers a wide range of investment opportunities tailored specifically for physicians. For further information call AMA Advisers.

MEDICAL MALPRACTICE INSURANCE

The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. More than 1500 Mississippi physicians are currently insured by MACM and extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-534-5433 or 800-898-0251 (In-State-WATS).

AMA Advisers - 200 N. LaSalle Street, #535, Chicago, IL 60601, 800-525-0864.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - (Evans and Giordano, Managing General Agency) - P.O. Box 12978, Jackson, MS 39296-2978, 601-957-5100 or 800-748-9713 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-200 or 800-325-4712 (In -State-WATS).

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Services

When you need information on a specific subject or association service, the following MSMA staff person(s) are available to assist you.

Address Changes • Barbara Shelton

Advertising • Ginger Cocke

Annual Meetings:
Delegates • Barbara Shelton
Scientific Exhibits • Ginger Cocke
Technical Exhibits • Kay Gatewood
Meeting Schedule • Ginger Cocke

Bills and Invoices • Robert Kidd

Board of Trustees & Officers • Charles Mathews

CommuniCare/Complaints from the Public/Office Brochures • Lora Lane

Continuing Medical Educations (CME) • Lora Lane

Component Medical Societies • Barbara Shelton

CPT/ICD-9 Inquiries • Debra Collins

Directories (MSMA and Auxiliary member listings) • Barbara Shelton

Dues (MSMA & Auxiliary) • Barbara Shelton

Government:
State • Clare Hester
National • Bill Roberts

Health Care Statistics and Data • Bill Roberts

Insurance Form Orders • Lucy Spence

Journal MSMA • Ginger Cocke

Legislative Activities • Clare Hester

Licensure • Bill Roberts

Mail Lists & Labels • Lucy Spence

Media (Radio, TV, Press) • Ginger Cocke

Medical Ethics • Bill Roberts

Medical Student Membership • Barbara Shelton

Medicare/Medicaid • Jackye Wiebelt

Member Benefits • Bill Roberts

MMPAC/AMPAC • Clare Hester

Physician Referrals • Lora Lane

Practice Management Workshops • Debra Collins

Public Information • Ginger Cocke

Resident Physician Membership • Barbara Shelton

Scientific Assembly • Ginger Cocke

Young Physician Section • Bill Roberts

MSMA Office

735 Riverside Drive
Jackson, MS 39202
(601) 354-5433

P. O. Box 5229
Jackson, MS 39296-5229
MS WATS (800) 898-0251

FAX: (601) 352-4834

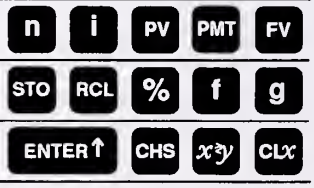
INVESTMENT MANAGEMENT *for* PHYSICIANS

For individual service and professional portfolio management, many physicians use Medley & Company.

- No-Load Mutual Funds/Other Securities
- 23 Years Experience
- Tested Asset Allocation Model
- Fee-Only Advisor

Medley & Company is a registered investment advisor and manages portfolios for individuals and pension and profit-sharing plans.

For a free brochure, call today.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 800 / 844-4123

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

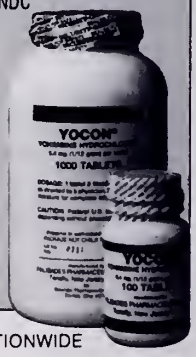
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, Increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Medical Organization

Drs. Ellis and Nina Moffitt Honored by Caduceus Club of Mississippi

On Friday evening, July 17, 1992 the Caduceus Club of Mississippi honored **Dr. Ellis M. Moffitt and Dr. Nina B. Goss-Moffitt** as the two people most responsible for the Mississippi State Medical Association's Physicians Recovery Program.

In 1978 the Drs. Moffitt were overwhelmed with the need for a program of "Doctors Helping Doctors". They were determined to establish a recovery program which could offer help without threat to physicians suffering from the disease of chemical dependency and make it work.

Well over two-hundred Mississippi physicians have accepted the program's offer to help, been treated through an approved treatment program and returned to the active practice of medicine and their families.

Mississippi was the first to pass the "Model Practice Act" as recommended by the American Medical Association. This opened the door for the Mississippi State Medical Association to develop an organized program of recovery and advocacy to offer the impaired physician. Dr. Nina Moffitt was working with the Department of Mental Health and serving as psychiatric consultant for the Mississippi Board of Medical Licensure. Dr. Ellis Moffitt was serving on the Board of Trustees of the Mississippi State Medical Association in 1978 when he and Dr. Nina Moffitt got resolutions from the Central Medical Society and the Clarksdale and Six Counties Medical Society to establish the impaired physicians program.

The Impaired Physicians Program operates under the aegis of the Mississippi State Medical Association, totally separate from the Medical Licensure Board, and has been supported over the years by contributions from members of the Mississippi State Medical Association, the MSMA Auxiliary, and the Medical Assurance Company of Mississippi.

Dr. Ellis Moffitt has served as Chairman of the Physicians Consultant Committee since the program began. This committee is composed of recovering physicians and non-addicted physicians with a working knowledge of the disease. Dr. Moffitt has traveled extensively throughout the state serving as part of the intervention team following a call regarding a sick doctor. He also directs problem verification and organizes interventions.

Dr. Ellis and Dr. Nina Moffitt have served faithfully as members of the Treatment Management Team of the Physicians Recovery Program. Dr. Nina Moffitt served for many years as the only psychiatrist member of the team. Dr. Ellis Moffitt is also currently serving as the program's director.

For further information about the Caduceus Club of Mississippi contact Nell Rowell at (601) 354-4446. ◻



Don Montgomery, DDS, of Jackson, at the mirocphone, was one of the presenters during the Caduceus Club's "Tribute to the Stars" honoring Drs. Ellis and Nina Moffitt.

Vicksburg AIDS Clinic Could Be Model For U.S. Small Towns

The 807 Clinic at the Warren County Health Department officially opened July 29 to provide services for Warren County HIV/AIDS patients. More than 75 people, including Vicksburg Mayor Robert Walker and State Health Officer Dr. Alton B. Cobb, were on hand for the ribbon-cutting ceremonies. Dr. Cobb says a new AIDS Clinic in Vicksburg will set an example for facilities across the country.

Dr. Robert Lee Giffin, a Vicksburg family physician, spearheaded efforts among local physicians. He said HIV/AIDs has been a topic among area physicians for some time. They were looking for ways to address the issue in the community from an education and treatment standpoint when the idea for the clinic came along. "I became involved because I perceive it (HIV/AIDS) as a growing problem that will involve all the community eventually," Giffin said. "The sooner we can get a system going, the sooner we will be able to serve the community."

In addition to Warren County Health Department personnel, 16 physicians help staff the clinic. Each physician donates up to eight hours each month to care for HIV/AIDS patients at the clinic.

Physicians donating their time to the clinic are **Dr. Robert Lee Giffin, Dr. Sandra Burford, Dr. Hildon Sessums, Dr. Tim Morris, Dr. James Ervin, Dr. John Ford, Dr. Russell Barnes, Dr. Randy Easterling, Dr. Lawrence Sutton,** Family Practice specialists; **Dr. Annette Low, Dr. Daniel P. Edney, Dr. Paul Pierce, Dr. Anita Tribble, Dr. Hubert Gaskin,** Internal Medicine; **Dr. Stephen Stagg,** Gastroenterology; and **Dr. Don Grillo** Ob/GYN.

"The congratulations for beginning this clinic belong to the people of Vicksburg and Warren County, to the mayor, the council, and the Board of Supervisors," said Dr. Don Grillo, West Central Public Health District V health officer. "This is an amazing effort."

The clinic staff concentrates on early intervention care for patients, referring patients to the University of Mississippi Medical Center for treatment when needed. Examples of care available at the clinic include patient and community education, general ambulatory care, and coordinated access to aerosolized pentamidine and drug therapy.

Salena Greenlee, coordinating nurse, Warren County Health Department, first approached the Warren County Board of Supervisors in late 1990 "for a little money to start treating HIV and AIDS patients in the area. I didn't really expect the money," she said, "but they voted and it was unanimous. They gave us $10,000."

That $10,000 blossomed by another $400,000 -- over three years -- in September 1991 when the city of Vicksburg got a federal grant under the Rural Health Outreach Program, one of 523 applications and only 100 funded.

Vicksburg Mayor Robert Walker called the cooperative effort in the community "a partnership of caring" The clinic has been open on a limited basis since March. "This is something we can all be proud of and indeed it is a step forward, but it should not be limited to just this," Walker said. "Everyone who has this virus, everyone who has this disease is entitled to top quality care."

The 807 Clinic -- named for its location at 807 Monroe Street in Vicksburg -- covers all aspects of HIV/AIDS from identification to treatment. Clinic organizers hope this unique care and outreach system will become a model for rural areas with similar needs throughout the nation. ◻

CMA Supports Discovery Clinic

The Central Medical Auxiliary presented a $500 check to the Mississippi State Department of Health Tuesday, July 21, for the Discovery Clinic for Teens in south Jackson.

CMA members Katherine Wells and Barbara Savoie presented the check to State Health Officer Dr. Alton B. Cobb and Dr. Will Sorey, chief, Bureau of Health Services. Rita Washington, secretary, and Linda Proctor, social worker, represented the Discovery Clinic staff. The $500 will purchase new blinds.

The Discovery Clinic is located in the Bel-Air Shopping Center on Highway 80. The Clinic provides complete health services for teens, including routine and sports physical examinations, diagnosis and treatment of illness, laboratory services, reproductive and mental

health services, wellness promotion, and health education.

Central Medical Auxiliary members are spouses of central Mississippi physicians. As part of their health services projects, CMA members contribute financial support and volunteer time to several programs.

CMA members are also donating time and money to help renovate the MSDH Blake Clinic for Children. Blake Clinic is part of the Children's Medical Program which provides medical and/or surgical care to children with chronic or disabling conditions.❑

MSMA Members Volunteer to Recruit New AMA Members

Seven Mississippi physicians have volunteered to help strengthen the voice of the American Medical Association as advocate for America's physicians and patients.

William A. Middleton, MD; Richard C. Reid, MD; W. W. Walley, MD; Earl L. Mahaffey, MD; Craig M. Slater, MD; Worley K. Stewart, MD and Willam C. Gates, Jr., MD have agreed to participate in the AMA's 1992 "On call: Member-Get-A-Member" program. Joining more than 500 physicians nationwide, these seven Mississippi physicians are recruiting their colleagues into AMA membership.

"By recruiting their colleagues, these physicians aid in the pursuit of the highest ideal in medicine -- to help all Americans lead healthier and more productive lives," noted James S. Todd, MD, AMA Executive Vice President.

Recruiters are recognized personally in AMA publications and with a selection of awards based on their recruiting success. The two top recruiters each receive an all-expense paid trip for two to the 1992 AMA National Leadership Conference.

New Members must join by October 1 for their recruiters to earn credit in the 1992 On Call program. The 1993 program will begin at the 1992 AMA Interim meeting in Nashville.❑

FOR COMMENTS OR QUERIES

The Editors of *Journal MSMA* invite you to comment on any material that appears in or is absent from the publication. If you have a query or comment, please sent it to: The Editor, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-



Dr. R. J. Field, Jr., above left, is pictured with 1992 President of the Southeastern Surgical Congress, Dr. Timothy Pennell. Dr. Pennell is professor of Surgery at Bowman-Gray School of Medicine in Winston Salem, North Carolina.

Dr. Field, of the Field Clinic in Centreville, Mississippi was awarded the Distinguished Service Award from the Southeastern Surgical Congress in Atlanta on May 30 - June 3. The Southeastern Surgical Congress is the second largest surgical organization in the world and meets in various major cities in the United States annually. Dr. Field has served on the Board of Councilors for the past 10 years, as well as being vice-president in 1988.

In addition to receiving the Distinguished Service Award, which is given to an individual surgeon for outstanding surgical leadership both in the private practice sector and the academic area, Dr. Field was elected president-elect of the Southeastern Surgical Congress to take office in 1994.

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39216

From the University of Mississippi Medical Center

Faculty Promotions at UMC

Five have been named to the faculty of the School of Medicine at the University of Mississippi Medical Center for the current academic session.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs and medical school dean, announced the appointments following approval by the Board of Trustees of State Institutions of Higher Learning.

Appointed were Dr. Ansel G. Anderson III, assistant professor of medicine; Dr. Ronald D. Davis, instructor in surgery (urology); Dr. Daccak Munzer, visiting professor of medicine; Dr. Charles L. Secrest, instructor in surgery (urology); and Dr. Anne R. Thompson, assistant professor of surgery.

Dr. Anderson earned the MD in 1988 at UMC. He took his residency in emergency medicine at the Medical Center.

Dr. Davis earned his MD in 1985 at the Medical College of Wisconsin. He took his residency in general surgery at the Columbus-Cuneo-Cabrini Medical Center, a program affiliate of the Northwestern University Medical School in Chicago. Dr. Davis also completed a urology residency at the Medical Center.

Dr. Munzer earned his MD in 1951 at the Faculte de Medicine de Paris in Paris, France. He took his training in gastroenterology in Paris and at the Temple University Hospital in Philadelphia. Dr. Munzer has served as chief of internal medicine at the Damascus Hospital in Damascus, Syria and chief of gastroenterology at the University of Damascus. From 1984 to 1986, Dr. Munzer was vice dean for academic affairs at the Medical College Damascus. Dr. Munzer is a professor of medicine at the Medical College Damascus University and Baylor College of Medicine in Houston.

Dr. Secrest earned the MD in 1986 at UMC. He took an internship and residency in general surgery at Baylor University Medical Center in Dallas, Texas. Dr. Secrest also completed a residency in urology at the Medical Center. In June, he completed a fellowship in adult and pediatric reconstructive urology at the Eastern Virginia Graduate School of Medicine in Norfolk, Va.

Dr. Thompson earned the MD at the University of Arkansas Medical Science Campus. She took her internship and residency in surgery at the University of Louisville. In 1989, she completed a endocrine research fellowship at Massachusetts General Hospital and the Harvard Medical School in Boston. Dr. Thompson was commissioned as a captain in the U.S. Army Reserve Medical Corps in 1988 and served as a staff surgeon in support of Operation Desert Storm in Fort Knox, Ky. This spring, she served as a lecturer in surgery at the University of Louisville. ❑

Dr. Guyton Receives Award

Dr. Arthur Guyton, professor emeritus of physiology and biophysics, received the American College of Physicians Award in San Diego during the convocation of the 73rd annual meeting. The award recognizes outstanding contributions to science as they relate

to the practice of medicine. Dr. Guyton's life-long work in cardiovascular physiology has had direct bearing on the way several conditions--such as congestive heart failure and high blood pressure--are tested.

A one-hour documentary on Dr. Guyton aired in April on Mississippi Educational Television as part of the "Mississippi Masters" series. ❑

Dr. O'Connell Serves as Society President

Dr. John O'Connell, chairman of the Department of Medicine at the University of Mississippi Medical Center, is president of the International Society for Heart and Lung Transplantation.

Dr. O'Connell said the society is the main voice of heart and lung transplant programs throughout the world. The 1500-member organization maintains a register of heart and lung transplants and publishes the *Journal of Heart and Lung Transplantation* which has a circulation of 2500.

Having already served a term as president-elect, O'Connell will serve as president for one year.

The current chairman succeeded Dr. Harper Hellems who retired in 1990 and came here in June, 1991, from the University of Utah Medical Center where he had been associate professor of medicine and medical director of the cardiac transplant program since 1986.

He is a manuscript consultant for the *American Journal of Medicine*, the *Journal of the American College of Cardiology* and the *New England Journal of Medicine*. ❑

UMC Division of Continuing Health Professional Education.
The University of Mississippi Medical Center
2500 North State Street
Jackson, Mississippi 39216-4505
(601) 984-1300

September

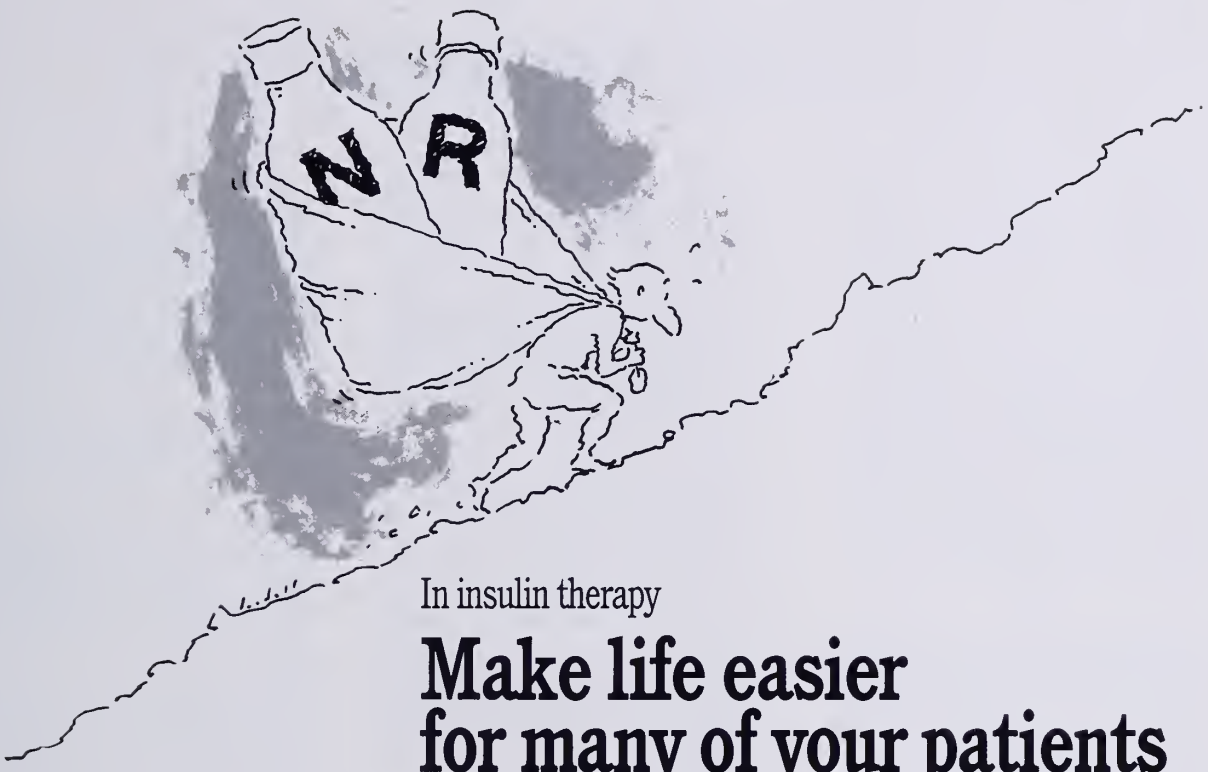
18-19	AAP Fall Meeting: Infectious Diseases is Pediatrics Ramada Renaissance Hotel, Jackson
24	Physiology of Aging University of Mississippi Medical Center, Jackson

October

7-8	Newborn Intensive Care Course (Day 1 & 2) University of Mississippi Medical Center, Jackson
17-18	Practical Seizure Management Decade of the Brain Diamondhead, Bay St. Louis
23-24	Wound and Hand Treatment University of Mississippi Medical Center, Jackson
27	AGRAMED Ramada Coliseum, Jackson
29	Pain and Its Management University of Mississippi Medical Center, Jackson

November

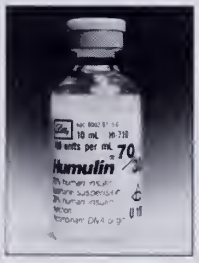
4-5	Newborn Intensive Care Course (Day 3 & 4) University of Mississippi Medical Center, Jackson
6-7	Decade of the Brain: Practical Aspects of Head Injury Case Management Ramada Renaissance Hotel, Jackson
7	Current Clinical Developments in Restorative Materials & Techniques University of Mississippi Medical Center, Jackson
21	Hypertension Seminar Ramada Renaissance Hotel, Jackson



In insulin therapy

Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer. No more mixing. No more mixing errors. All of which makes living with diabetes a little easier for patients. And compliance a lot easier to achieve.



Humulin® 70/30

70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

The patient-friendly premix

Global Excellence in Diabetes Care

Eli Lilly and Company
Indianapolis, Indiana
46285

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

HI-7905-B-249327 ©1992, ELI LILLY AND COMPANY

New Members

Beeman, S. Kenn, Tupelo. Born September 3, 1955; MD, Vanderbilt University School of Medicine, Nashville, TN, 1981; pediatric & medicine residency, Same, 1981-82; surgery residency, same, 1982-89; thoracic & cardiovascular surgery residency, Indiana University Medical Center, Indianapolis, IN, 1990-92; elected by Northeast Mississippi Medical Society.

Burroughs, Judy F., Greenville. Born Knoxville, TN, March 19, 1944; MD, Vanderbilt University School of Medicine, Nashville, TN, 1970; interned and pathology residency, same, 1970-71 & 1973-74; pathology residency, Medical College of Virginia, Richmond, VA, 1972-73; elected by Delta Medical Society.

Braden, Michael R., Sr., Durant. Born New Orleans, LA, November 10, 1945; MD, Meharry Medical College, Nashville, TN, 1977; interned one year Hubbard-Meharry Medical Center, Nashville, TN; elected by North Central Medical Society.

Duggan, Frederick T., Meridian. Born Nashville, TN, June 8, 1961; MD, University of Mississippi School of Medicine, Jackson, MS 1987; interned and medicine residency, University Medical Center, Jackson, MS, 1987-90; fellowship pulmonary disease, same, 1990-92; elected by East Mississippi Medical Society.

Ferguson, J. Scott, Starkville. Born Kosciusko, MS, April 17, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; medicine residency, Memorial Medical Center, Savannah, GA, 1989-92; elected by Prairie Medical Society.

Gillespie, J. Barry, Greenville. Born Jackson, MS, November 15, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; medicine & pediatric residency, University of Arkansas Medical Center, Little Rock, AK, 1985-89;elected by Delta Medical Society.

Gorton, Alice M., Carthage. Born Perth, Australia, December 6, 1953; MD, University of Cincinnati College of Medicine, Cincinnati, OH, 1988; interned, Same, one year; family practice residency, University Medical Center, Jackson, MS, 1989-91; elected by Central Medical Society.

Grafton, Thomas W., Laurel. Born Laurel, MS, December 20, 1945; DO, West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1989; interned one year, Metropolitan General Hospital, WV; family medicine residency, University Medical Center, Jackson, MS, 1990-92; elected by South Mississippi Medical Society.

Karstens, Allen E., Hattiesburg. Born Columbus, GA, May 6, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1979; interned & pediatric residency, University of Arkansas, Little Rock, AK, 1979-82; elected by South Mississippi Medical Society.

Havens, Michael R., Batesville. Born Greenwood, MS, June 19, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; family medicine residency, same, 1987-90; elected by North Mississippi Medical Society.

Horton, William L., Amory. Born Cleveland, MS, September 29, 1959; MD, West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1988; interned and medicine residency, Doctors Hospital, Columbus, OH, 1988-92; elected by Northeast Mississippi Medical Society.

Houston, Karen J., Jackson. Born Ames, IA, February 19, 1947; MD, University of Mississippi School of Medicine, Jackson, MS 1986; pathology residency, same, 1986-87; diagnostic radiology residency, same, 1987-91; elected by Central Medical Society.

Jackson, John R., Jr., Hattiesburg. Born Hattiesburg, MS, October 17, 1936; MD, University of Mississippi School of Medicine, Jackson, MS, 1962; pediatric residency, Baylor University College of Medicine, Houston, TX, 1966-68; elected by South Mississippi Medical Society.

Kent, Ronald S., Hattiesburg. Born Brookhaven, MS, December 4, 1952; MD, University of Mississippi School of Medicine, Jackson, MS 1978; pediatric residency, Same, 1978-81; elected by South Mississippi Medical Society.

Lucas, Aubrey B., Jackson. Born Metairie, LA, November 12, 1960; MD, University of Mississippi School of Medicine, Jackson, MS 1986; ortho. surgery residency & hand surgery residency, Greenville Hospital, Greenville, SC, 1986-90; elected by Central Medical Society.

Mace, James A., Long Beach. Born Luling,TX, May 29, 1954; MD, University of Mississippi School of Medicine, Jackson, MS, 1984; interned one year, Baptist Hospital, Memphis, TN. Elected by Coast Counties Medical Society.

McKellar, David L., Hattiesburg. Born Laurel, MS, April 13, 1960; MD, Louisiana State University School of Medicine, Shreveport, LA, 1986; anesthesiology residency University of Texas Medical Center, Galveston, TX 1986-89; elected by South Mississippi Medical Society.

Merritt, Gregory W., Hattiesburg. Born Tylertown, MS, April 24, 1956; MD, University of Mississippi School of Medicine, Jackson, MS, 1981; pediatric residency, Same, 1981-84; elected by South Mississippi Medical Society.

Morgan, Dennis P., Jackson. Born Grenada, MS, April 25, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; interned, medicine residency & oncology fellowship, University Medical Center, Jackson, MS, 1987-92; elected by Central Medical Society.

Parker, Tammie B., Jackson. Born Jones City, MS, April 24, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned and medicine residency, Same, 1989-92; elected by Central Medical Society.

Phillips, Mark T., Meridian. Born Austin, TX, September 25, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; general surgery residency, Baylor Medical Center, Houston, TX, 1985-87; urology residency, University Medical Society, Jackson, MS, 1987-90; elected by East Mississippi Medical Society.

Rigby, Joel L., Tupelo. Born Oklahoma City, OK, December 1, 1958; MD, Louisiana State University School of Medicine, Shreveport, LA, 1986; interned & urology residency, Same, 1986-92; elected by Northeast Mississippi Medical Society.

Robbins, Kenneth K., Jackson. Born Mississippi, December 11, 1955; MD, University of Mississippi School of Medicine, Jackson, MS, 1983; interned and pediatric residency, same, 1983-86; neonatology residency, Vanderbilt University Medical Center, Nashville, TN, 1989-92; elected by Central Medical Society.

Ruvinsky, Ernesto D., Yazoo City. Born Argentina, September 28, 1946; MD, National University of Cordoba, Argentina, 1970; obg residency, University Medical Center, Jackson, MS, 1973-76; elected by Delta Medical Society.

Sheffield, Eugene G., Gulfport. Born Memphis, TN, July 25, 1958; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; interned one year, Baylor College of Medicine, Houston, TX; diagnostic radiology residency, Parkland Memorial Hospital, Dallas, TX, 1986-90; pediatric radiology residency, Children's Medical Center, Dallas, TX, 1990-91; elected by Coast Counties Medical Society.

Short, Valerie A., Jackson. Born Hampton, VA, October 28, 1958; MD, Vanderbilt University School of Medicine, Nashville, TN, 1985; obg residency, Hubbard Hospital, Meharry Medical Center, Nashville, TN 1985-89; elected by Central Medical Society.

Smith, Elizabeth H., Pascagoula. Born Richmond, VA, October 1, 1949; MD, University of Virginia School of Medicine, Charlottesville, VA, 1976; interned one year, Same; therapeutic radiology residency, University of Florida Medical Center, Gainesville, FL, 1980-83; elected by Singing River Medical Society.

Stone, Reuben H., Jackson. Born Biloxi, MS, April 29, 1958; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; internal medicine & cardiology fellowship, Same, 1989-92; elected by Central Medical Society.

Summers, Jeffery T., Jackson. Born Washington, DC, March 31, 1957; MD, University of Mississippi School of Medicine, Jackson, MS 1983; interned and anesthesiology residency Brooke Army Medical Center, San Antonio, TX, 1983-87; pain management fellowship, University of Texas Health Science Center, San Antonio, TX, 1987-88; elected by Central Medical Society.

Thompson, James R., Jackson. Born Payson, UT, October 14, 1951; MD, University of Cincinnati School of Medicine, Cincinnati, OH, 1988; interned one year, Same; emergency medicine residency, University Medical Center, Jackson, MS, 1989-92; elected by Central Medical Society.

Tsao, Audrey K., Jackson. Born Madison, WI, March 22, 1960; MD, Cornell University Medical College, New York, NY, 1986; orthopaedic surgery residency, Northwestern University Medial Center, Chicago, IL, 1986-91; fellowship, arthritis/total joint reconstruction, Johns Hopkins, Baltimore, MD, 1991-92; elected by Central Medical Society. ❑

We earn
your trust every day.℠

Trustmark℠
National Bank

Jackson/Bogue Chitto/Brandon/Brookhaven/Canton/Clinton/Columbia
Florence/Flowood/Georgetown/Gloster/Greenville/Greenwood/Hattiesburg
Hazlehurst/Hernando/Horn Lake/Leland/Liberty/Madison/Magee/McComb
Olive Branch/Pearl/Pelahatchie/Petal/Richland/Ridgeland/Southaven
Tylertown/Wesson

Member FDIC



RUN A SPECIAL PRACTICE.

Today's Air Force has special opportunities for qualified physicians and physician specialists. To pursue medical excellence without the overhead of a private practice, talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay each year that are part of a medical career with the Air Force. Discover how special an Air Force practice can be. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

To Relieve the Symptoms of Stress From Travel



Call Avanti Travel, Inc. For All Of Your Business and Leisure Trips for Stress-Free Travel!

Avanti Travel is staffed with highly professional consultants who have extensive backgrounds in the travel industry. Avanti's specialists offer you the personal service and attention to details that you expect and deserve.

Avanti Travel offers you these amenities:

- 24- hour reservation service
- Toll free nationwide numbers and toll free numbers from 39 foreign countries
- Guaranteed lowest applicable airfares
- Last seat availability on major airlines
- Savings up to 45% on selected hotels in the United States and throughout the world
- All day ticket delivery and airport "will-call" box
- Lost luggage tags

The next time you make travel arrangements, Call Avanti Travel, Inc. for stress-free travel.



Three Lakeland Circle • Jackson, Mississippi 39216 • 981-9111
Call Toll-Free Nationwide 1-800-748-8744

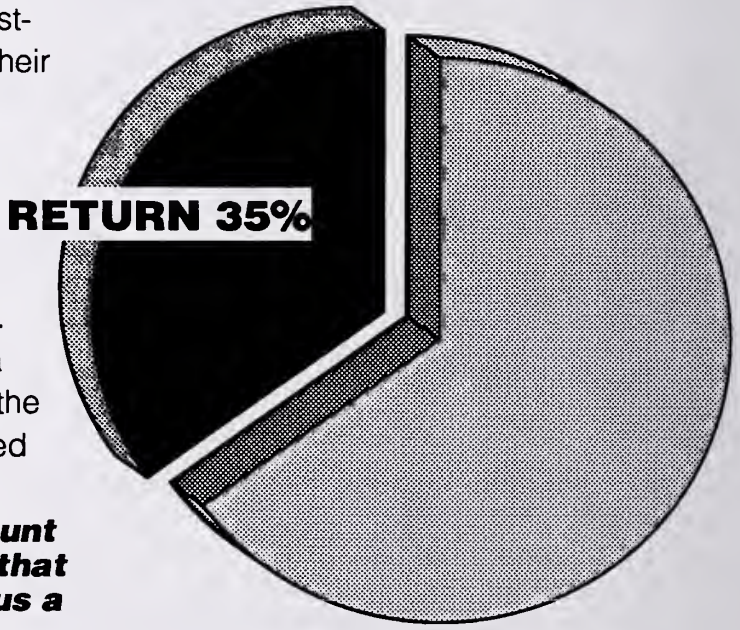
In 1991 our retirement funds earned an average 35% return on investments.*

Employer Plus offers our clients a family of select mutual funds, from one of the nation's leading investment banking firms, to use for their retirement plan investment.

Recent figures for the year 1991, show the ten mutual funds that we most recommended for our clients, averaged a **35%** overall return. One of the ten produced over a **56%** return. the highest, while the lowest return of the ten produced just under a **20%** return.*

If your retirement account is not producing a return that you are happy with, give us a call.

We can help.



Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

**Past performance is no guarantee of future returns.*

© 1992 Employer Plus. All rights reserved.

Personals

George Abraham of Vicksburg has been elected treasurer of the Board of Directors of the Mississippi Foundation for Medical Care.

Mark Allen of Quitman has been named a Fellow of the American Academy of Family Physicians.

Paul M. Allen, a gynecologists and obstetrician practicing in Pascagoula, has co-authored an article entitled: *A New Instrument for the Visualization and Laser Treatment of the Female Urethra and Trigone* which has been published in the June 1992, edition of the *International Urogynecology Journal*. Dr. Gordon D. Davis of Phoenix, Az. is co-author.

Charles Patten Bass, of Columbia, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Mike Beall of Jackson is currently serving as president of the Mississippi Affiliate of the American Diabetes Association.

Kenn Beeman has associated with Surgery Clinic of Tupelo, PA, for the practice of Thoracic and Cardiovascular Surgery.

Douglas E. Bowden has associated with **John F. Lucas, Jr.**, and **John F. Lucas, III**, for the practice of General Surgery, Greenwood, Ms.

Leonard Brandon of Starkville was recently elected vice chairman of the board of directors of the Mississippi Foundation for Medical Care.

James A. Bruce of Jackson announces the opening of a satellite clinic for medical and surgical treatment of eye diseases, The Hammond-Routt House, 109 South Natchez, Kosciusko, Ms.

C. Ron Cannon of Jackson attended the Long Range Planning Committee for the American Academy Otolaryngology-Head & Neck Surgery in Washington, D.C. He is also serving as president of the Mississippi EENT Association, 1992-93.

Edgar N. Donahoe, Jr. has associated with the Hull Brothers Clinic, Indianola in family practice.

Joseph D. Edwards, Jr., has associated with **Leslie L. Jones** and **C. Stephen Perry** for the practice of Pediatrics at Madison-Ridgeland Children's Clinic.

Juliana Ellis has associated with **Peter S. Kamp** and **William S. Turner** at the South Mississippi Psychiatric Group, for the practice of Adult Psychiatry, 1101A South 28th Avenue, Suite 1, Hattiesburg.

Robert Evans of Jackson is serving as president-elect of the Mississippi Affiliate of the American Diabetes Association.

Scott Ferguson has associated with **Ben Sanford** at the Starkville Internal Medicine Clinic, 104 Doctors Park, Starkville, MS.

Kevin Fisher has associated with **Joseph Salloum** of Hattiesburg in the practice of Radiation Oncology.

Gardner L. Fletcher has associated with Medical Group of Hattiesburg for the practice of Internal Medicine and Pulmonary/Critical Care Medicine, Methodist Medical Park, 101 Asbury Circle, Hattiesburg.

James Barry Gillespie has associated with **Ben P. Folk, III** and **Allen H. Thompson** for the practice of Internal Medicine, 1705 Hospital Street, Greenville.

David H. Gilliland has associated with Surgery Associates, PA, for the practice of General and Vascular Surgery, 850 South Madison, Tupelo.

Barbara B. Goodman has associated with **Stephen M. Shirley** at the New Albany Family Clinic for the practice of Family Medicine, 400 Doctors' Drive, New Albany.

Thomas W. Grafton has associated with the Laurel Family Clinic, PA, 103 South 12th Avenue, Laurel, for the Practice of Family

Medicine.

Marion V. Green of Holly Springs has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Stephen L. Harless announces the opening of his practice in Family Medicine, 101 Weems Street, Purvis.

D. Stanley Hartness, Jr., of Kosciusko, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Michael R. Havens has associated with the Batesville Clinic in the practice of Family Medicine, 107 Eureka Street, Batesville.

R. Glenn Herrington has associated with **V. John Ford, III**, for the practice of Ophthalmology, Medical Arts East Building, 1190 North State Street - Suite 403, Jackson.

J. Edward Hill of Hollandale has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Kevin L. Hitt has associated with the Meridian Anesthesiology Group, P.A., 1214 23rd Avenue, Meridian.

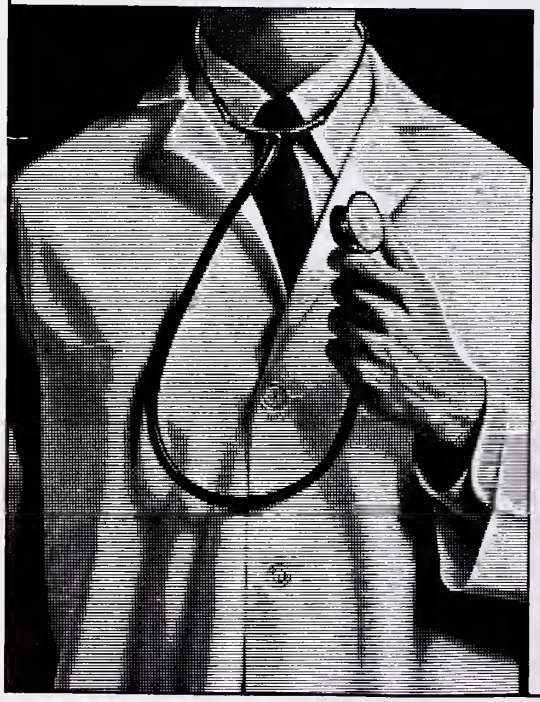
Martin L. Howard, Jr., has associated with **Steven C. Williams** in General Vascular Surgery Specialists, Medical Arts Building, Suite 1200, 300 Rawls Avenue, McComb.

Rife Edward Huckabee has associated with Greenwood Radiology and **James V. Ferguson, Jr.**, 1605 Strong Avenue, for the practice of Diagnostic Radiology.

Dan W. Jackson of Rolling Fork has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Stephen P. Johnson has associated with **Daniel J. Peasley** of the Gastroenterology Clinic Laurel.

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect :

ARMY HEALTH CARE TEAM

(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.

Scott B. Jordan has joined the Rush Medical Group, P.A. of Meridian for the practice of Obstetrics and Gynecology.

Leland R. Kendrick announces the opening of his office for the practice of Family Medicine, 252-A Highway 90, Bay St. Louis.

Dale Loiacano of Bay St. Louis has been named head of the anesthesiology department at Hancock Medical Center.

Roberto H. Lopez announces the opening of his office for the practice of Internal Medicine at 1018 6th Avenue, Suite B, Picayune.

J. Keith Mansel announces the opening of his office for the practice of Pulmonary Diseases and the formation of Oxford Lung Physicians.

Chris L. Mauldin, has associated with the Westridge Family Clinic, 307 S. 13th Avenue, Laurel.

John Morrison of Jackson is serving as vice president of the Mississippi Affiliate of the American Diabetes Association.

Eric J. Pearson has associated with the Meridian Anesthesiology Group, P.A., 1214 23rd Avenue, Meridian.

Marion Reed, a pediatrician, has joined the staff of the Aaron E. Henry Community Health Services Center. Dr. Reed is also Medical Coordinator of the Mississippi Children's Health Project.

Toni B. Richardson has associated with William W. East and T. Keith Everett for the practice of Ophthalmology, 2300 12th Street, Meridian.

Joel L. Rigby had associated with Urology, PA, 605 Garfield Street, Tupelo, for the practice of Urology.

C. J. Sanders, a Tupelo gynecologist-obstetrician received the Golden Tongue Blade Award as North Mississippi Medical Center's Doctor of the Year for the second consecutive year.

Robin H. Schwartz announces the opening of her practice of Anesthesiology, Southwest Regional Medical Center, McComb.

COME SEE THE BEAUTIFUL NEW MODELS NOW!

HARRELD
CANTON

Member of CENTRAL MISSISSIPPI Chevy Dealers

CALL US 1-800-451-3908 TOLL FREE!

MISSISSIPPI'S FAVORITE COMBINATION CHEVY-OLDS-GEO DEALER

HARRELD CHEVY-OLDS-GEO

Canton 859-1611 Highway 51 South - Canton, MS Jackson 354-2233

Charles L. Secrest has associated with Mississippi Urology Clinic, P.A., for the practice of Adult and Pediatric Genitourinary Reconstructions and General Urology, Watkins Medical Building, 1421 N. State Street, Suite 403, Jackson.

John M. Senter and **Ronald Luethje** announce the relocation of their practice, Marion County Surgical Clinic, 910 Sumrall Road, Columbia.

Michael B. Shrock of Philadelphia has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Harper Stone has associated with the Jackson Heart Clinic, P.A., for the practice of Cardiology at St. Dominic Medical Office, Suite 450, 971 Lakeland Drive, Jackson.

David M. Thompson has associated with the Street Clinic, Vicksburg, in the practice of Orthopedics.

Gregg A. Willis has associated with **Robert A. Kennedy** in the Woman's Clinic in the practice of obstetrics and gynecology.

Thurston E. Wilkes, II, announces the opening of the Batesville office of the Oxford Urology Clinic, for the practice of adult and pediatric urology. ❑

Correction

Under Physician's Recognition Award in the July 1992 Issue, *Journal MSMA*, Dr. O. Lynn Hamblin's name was listed incorrectly.

The recognition should read as follows:

Northeast Mississippi Medical Society
O. Lynn Hamblin, MD

Physicians' Recognition Award

Eight MSMA members were named recipients of the AMA Physicians' Recognition Award in June 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by medical society.

Coast Counties Medical Society
David L. Clippinger, MD
Robert Hiram Middleton, MD

Delta Medical Society
J. Edward Hill, MD

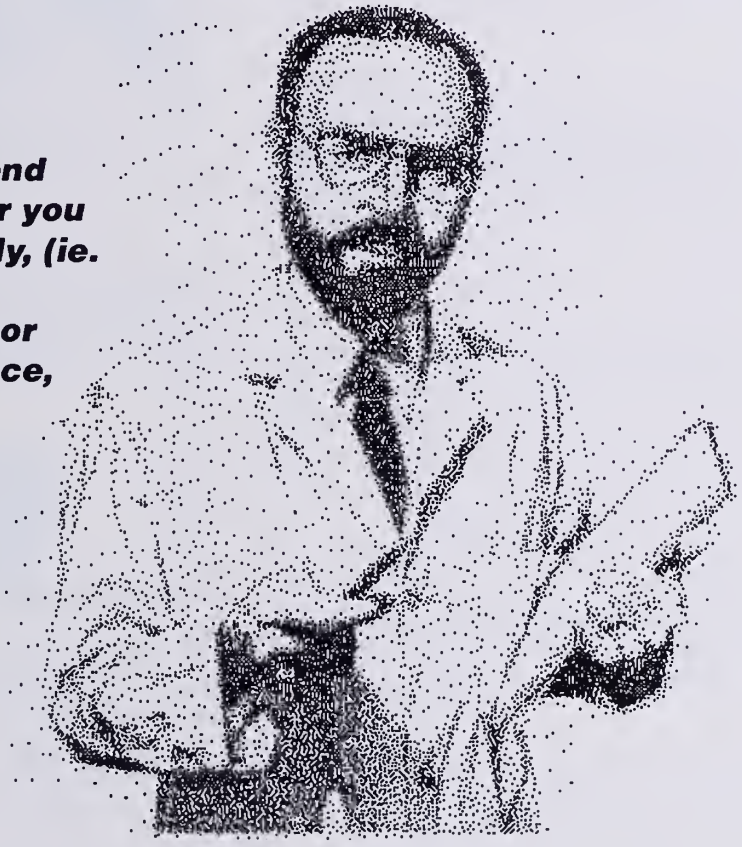
Northeast Mississippi Medical Society
Jessie Roma Taylor, MD

Singing River Medical Society
Paul Harold Moore, MD

South Mississippi Medical Society
John Richard Harper, MD

South Central Medical Society
Ralph L. Brock, MD
James W. Pressler, MD

What can Employer Plus do for me personally, as a doctor?



For every dollar you spend on benefits for you and your family, (ie. health dental, disability, life or vision insurance, as well as dependent care or medical costs) we can save you at least 38 cents in Federal and State taxes on each dollar you are currently spending.

The choice is yours, do you continue to pay your money to the government or do you put more money in your pocket? Contact Employer Plus today, we'll discuss all the details on a personal and confidential basis. Call us

Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.

Placement Service

FAMILY PRACTICE/ ER PHYSICIANS NEEDED FOR FILL-IN OR REGULAR PART-TIME BASIS AT A NORTH EAST JACKSON CLINIC. CALL 957-2273.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

MOONLIGHTING IN MISSISSIPPI



SINCE 1977, PRI-MED HAS BEEN STAFFING EMERGENCY DEPARTMENTS IN MISSISSIPPI, ARKANSAS, TENNESSEE, AND CALIFORNIA. PRI-MED OFFERS A WIDE RANGE OF OPPORTUNITIES FOR THE PHYSICIAN, FROM THE OCCASIONAL NIGHT SHIFT TO THE FULL-TIME EMERGENCY ROOM DIRECTORSHIP. FOR MORE INFORMATION ON MOONLIGHTING IN YOUR AREA PLEASE CALL JOE PAT JUNKIN OR PATSY MCDANIEL AT:

1-800-821-6382 - OUTSIDE TENNESSEE
1-901-685-9305 - IN TENNESSEE

Equal Opportunity Employer

PRI-MED
primary medicine

6263 POPLAR AVENUE, SUITE 700 • MEMPHIS, TENNESSEE 38119

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

Items for the Placement Service should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

The advertising rate is $2.00 per line or $75.00 per 1/4 page block. Rate cards available upon request.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

FP, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

FULL-TIME PHYSICIAN NEEDED. NORTH MISSISSIPPI AREA. BUSY FAMILY PRACTICE. GUARANTEE PLUS PARTNERSHIP OPPORTUNITY. (901) 753-7321.



Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

Family Practitioners, BC/BE: Liberty, Mississippi

Excellent opportunity for two family physicians to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $75,000 - $85,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule.

The successful applicants may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment; and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability.

Contact Pam Poole, Amite County Medical Services, Inc., P.O. Box 511, Liberty, MS 39645 (601) 657-4326.

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Classified

Modern Family Medical Clinic For Sale in Ridgeland, MS (Northpark Area off Pear Orchard at Lake Harbour). 3000 Sq. Ft. Clinic + All Equipment (Lab • X-Ray • Surgery). Established for 14 yrs - Doctor retiring. Great Opportunity for 1 - 2 Drs. $20K Below appraisal & equipment heavily discounted. (601) 856-6933.

Investment Property: Office and/or retail and warehouse space. Excellent location next to Woman's Hospital. Two buildings total 18,000 Sq. Ft. **Call 939-0935.**

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captain Mike McRaney, (601) 857-9462, PO Box 999, Biloxi, MS.**

Medical clinic for a 1 to 3 physician occupancy. Equipped with supplies, furniture and instruments probably sufficient to institute immediate practice. Includes patient waiting area, 3 business offices, 9 examination rooms, 3 treatment rooms, lab, x-ray, staff lounge and storage rooms. **Located in downtown Moss Point,** an industrial city of 17837, with 2 rivers, Interstate 10 and airport within city limits. Adjacent to post office, banks, pharmacy. Ample parking. Convenient to Singing River Hospital. Contact Mrs. Barrett at John Jones and Associates. 1-800-748-8650.

KODAK DTSC, DT-60 & DTE COMPLETE WITH INSTRUCTIONS, MANUALS & SPECIMEN TUBES, TAKE UP NOTES • 601-624-5464 OR 601-627-1448.

Medical Office Space Available for Lease
Ridgeland, Mississippi

Office space consists of 25 X 40 feet, or 1,000 square feet, available August 15, 1992, located in shopping center on Lake Harbour Drive at Highway 51. Space includes waiting room and receptionist area, private office with rest room, laboratory, 3 examination rooms and patient's rest room. Call 859-5251.

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Index to Advertisers

Avanti 345

CancerPay Plus **4**
CompHealth 321

Deposit Guaranty Investments ..... **third cover**
Disability Determination 352
Doctors Insurance Reciprocal 327

Eli Lilly & Co. - Humulin 341
Employer Plus, Inc. ..... 346 & 351

Harreld Chevrolet-Oldsmobile 349

Medical Assurance Co. of MS ..... **second cover**
Medley & Company 334
MS Emergency Association 353
MS Physicians Insurance Company **6**
MSMA Benefit Plan & Trust 338

Palisades Pharmaceuticals, Inc - Yocon 334
Premier Printing 321
PRI-MED, Inc. 352

Searle - Calan SR ..... **fourth cover**

The Doctors' Company 318
Trustmark 344

US Air Force 344
US Army Active 348
US Army Reserve 322



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS.

PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

LIBRARY
SEP 2 [illegible]
N.Y. Academy of Medicine

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

For the many faces of mild hypertension

MILD



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION[1]*

- Effective 24-hour control[2]
- Single-agent efficacy
- Well tolerated†
- No adverse effects on total cholesterol, plasma glucose levels, renal function,‡ or serum electrolytes[3-6]

ONCE-DAILY
Calan® SR
verapamil HCl
SUSTAINED-RELEASE CAPLETS
120 mg
180 mg
240 mg

For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

2/13/92 • P92CA7196V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

© 1992 Searle

P92CA7233T

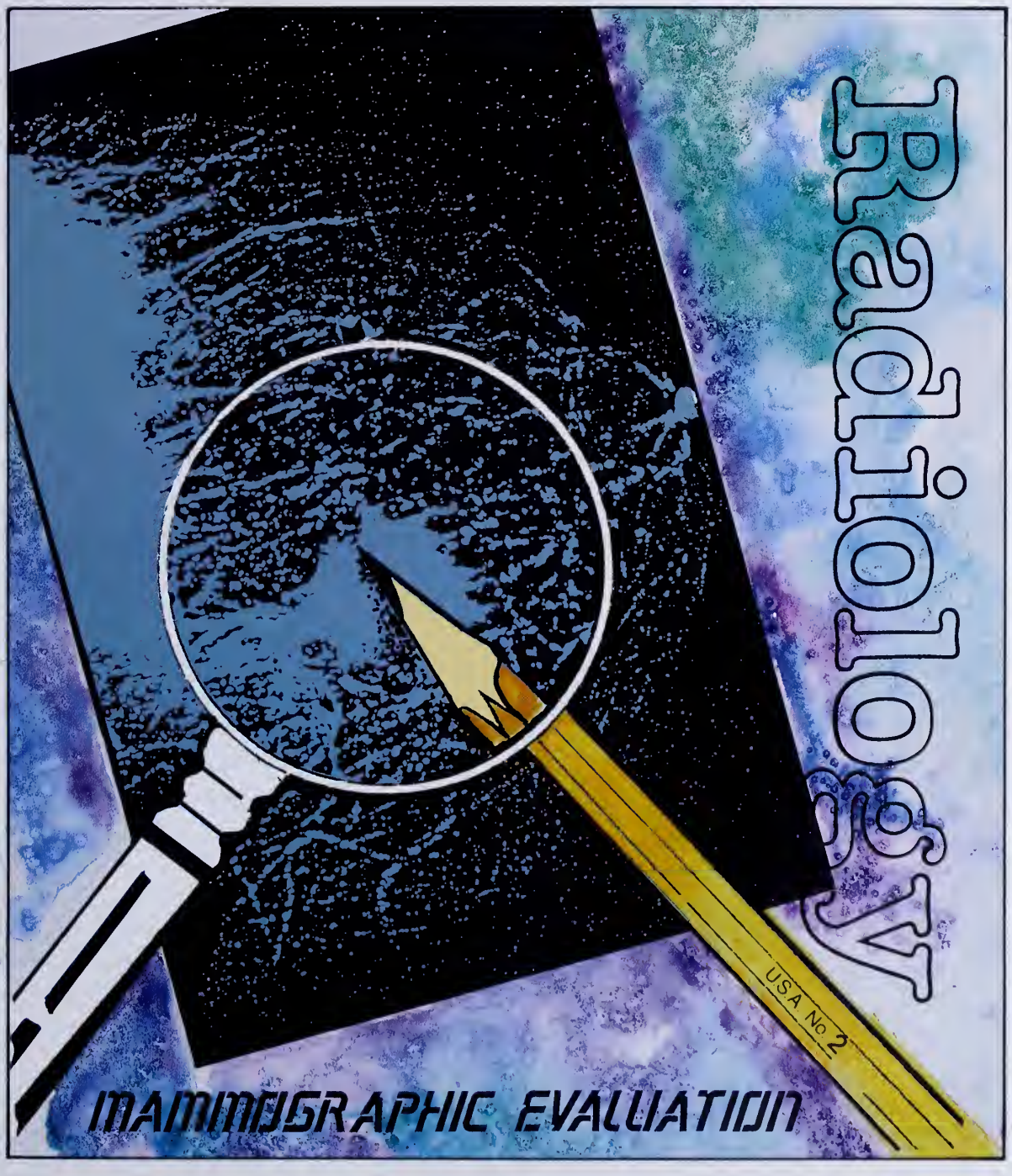
SEARLE

Box 5110
Chicago, IL 60680-5110

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

OCTOBER 1992



You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39296-5509

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

OCTOBER 1992 VOLUME XXXIII NUMBER 10

SCIENTIFIC ARTICLES

Acute Urinary Retention Due To A Free-Standing Broad Ligament Leiomyoma 355
Michel E. Rivlin, MD; Ramon P. McGehee, MD; Rameshkumar B. Patel, MD and G. Rodney Meeks, MD

Evaluation of Mammographic Stellate Lesions 359
W. Mel. Flowers, Jr., MD and, Cynthia I. Powers, MD

EDITORIALS

T. I. A. and F. F. H. (Transient Ignorance & Apathy And Free Floating Hostility) 362
William C. Gates, MD

Sports Page Medicine 363
Myron W. Lockey, MD

DEPARTMENTS

Letters 365
Current Opinions 367
Medical Organization 369
From the University of Mississippi Medical Center 373
Personals 377
Placement Service 382

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD,
Chairman
William E. Godfrey, MD
Leslie E. England, MD
and the editors

THE ASSOCIATION
William C. Gates, MD
President
Don Q. Mitchell, MD
President-Elect
D. Stanley Hartness, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6396) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.

THE UNITED STATES ARMY RESERVE

HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

U.S. ARMY RESERVE HEALTH CARE TEAM
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201
OR CALL COLLECT: (205) 930-9719 or 9727

The Hospital Medical Staff Section
Twentieth Assembly Meeting
December 3 - 7, 1992
Opryland Hotel
Nashville, Tennessee

Highlights of the Interim Meeting will include an educational program on:

Part I:
A Futurist's Picture of Health Care 2000

A highly recognized consultant in health care issues will provide his perspective of the factors that will influence the reform of the health care system in the decades to come. Having painted a picture of Health Care 2000, the futurist will respond to questions of a reactor panel which will focus on:

- the role of organized medicine in framing the future health care delivery system,
- the role physicians will play in shaping the future and assuring adequate access to high quality health care services, and
- the impact that anticipated changes in the health care delivery system will have on the hospital medical staff's relationship with the community outside the hospital setting, including the payers.

Part II:
Physician / Hospital Organizational Models for the Future

The relation of the hospital with members of its medical staff will be substantially impacted by the forces that are shaping national health care policy and the health care delivery system of the future. The HMSS Representatives will learn:

- what some states are doing to serve as "laboratories" for alternative health care delivery systems,
- what the AMA is doing to study and advise physicians on the appropriateness of various physician / hospital organizations, and
- what one consultant anticipates will ultimately be the prognosis for organizational relationships between health care providers.

For information contact:

Hospital Medical Staff Services
American Medical Association
515 North State Street
Chicago, IL 60610
Phone / 312 464-4754 or 464-4761



Hospital Medical Staff Section

American Medical Association

Physicians dedicated to the health of America



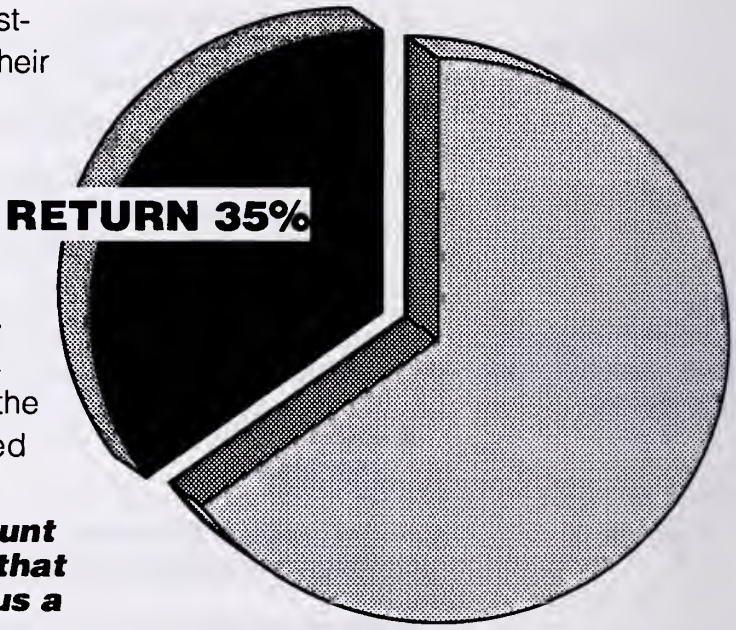
In 1991 our retirement funds earned an average 35% return on investments.*

Employer Plus offers our clients a family of select mutual funds, from one of the nation's leading investment banking firms, to use for their retirement plan investment.

Recent figures for the year 1991, show the ten mutual funds that we most recommended for our clients, averaged a **35%** overall return. One of the ten produced over a **56%** return. the highest, while the lowest return of the ten produced just under a **20%** return.*

If your retirement account is not producing a return that you are happy with, give us a call.

We can help.



Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

**Past performance is no guarantee of future returns.*

© 1992 Employer Plus. All rights reserved.

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 10

Health-care survey puts state in 49th

Jackson, MS - Mississippi's economic and social woes all but assure its citizens' health will remain near the worst in the country, said Dr. Alton Cobb, the state's health officer.

Dr. Cobb responded to an insurance company survey rating Mississippi 49th in health issues. The rankings were not an indication of health care quality, Cobb said.

"Frankly, you could predict where Mississippi would stand because of its low per capita income and the high black population that has shown to be more sensitive to health conditions like diabetes and hypertension," Cobb said.

Only West Virginia, which maintained its ranking from a year ago, trailed the Magnolia State in the poll conducted by Northwest National Life Insurance Co. of Minneapolis. Mississippi was 47th the last two years.

Minnesota was deemed the healthiest of the 50 states by the company's panel of researchers. Hawaii was second. Mississippi was rated in the bottom 20 percent in 10 of the 17 categories used to rank the 50 states.

The categories included traditional health-care areas, such as disease rates, and non-traditional areas, such as unemployment rates, that affect health care.

Mississippi was 47th in unemployment at 8.6 percent in 1991 and 45th in high-school graduation rate at 64.2 percent. The leaders in the respective categories were Nebraska, 2.7 percent, and Iowa, which graduated 87.5 percent of its seniors.

"To improve, we have to get away from the mentality of just educating the current class of students, but also educating the providers like me, legislators, the governor," said Joe Haynes, deputy superintendent for Jackson Public Schools.

In medical areas, Mississippi was last in mortality with a rate of 616 deaths per 100,000 population; premature death, 7,094 per 100,000; and risk for heart disease.

The state received its best marks in lack of violent crime, 16th; incidence of smoking, 18th; and reports of infectious disease, 21st.

"We didn't learn much from this report we didn't know before," said State Epidemiologist Dr. Ed Thompson. "The social and economic areas need to be addressed by the state's policy makers." Other changes will have to come from individuals, he said.

Judge throws out state abortion rule

Jackson, MS - A circuit judge has tossed out state Health Department rules that prohibit clinics in Mississippi from performing abortions beyond 16 weeks of pregnancy. Hinds County Chancellor Patricia Wise barred the State Department of Health from enforcing a regulation that would have prohibited the late-term abortions in abortion clinics. Wise's order is in effect until she issues a final decision in an appeal filed challenging the health regulation.

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



Medical Assurance Company has proven time and again the benefits of affiliation with a company dedicated to Mississippi physicians. Doctors don't want decisions regarding their practice made by people they have never met with offices thousands of miles away.

When actuarial consultants advised MACM that it might be necessary to raise premiums for pediatricians due to claims losses, the Company spearheaded a mandatory statewide Risk Management Program to address the problem.

By working with us, they were able to reduce losses among pediatricians, thereby avoiding rate increases which would have had a negative impact on health care throughout the State.

MACM insures more Mississippi physicians than any other company for good reason -- they *are* Mississippi physicians. Who could know our needs better?

Dr. Elizabeth Keeling is a Board Certified Pediatrician practicing in Jackson, Mississippi.

MEDICAL ASSURANCE COMPANY OF MISSISSIPPI
1-800-325-4172 or
601/353-2000 in Jackson
735 Riverside Drive ■ Suite 307
Jackson, MS 39202

Acute Urinary Retention Due To A Free-Standing Broad Ligament Leiomyoma

MICHEL E. RIVLIN, MD
RAMON P. MCGEHEE, MD
RAMESHKUMAR B. PATEL, MD
G. RODNEY MEEKS, MD

A 38-year-old woman who had used oral contraceptives continuously since age 22 presented with acute urinary retention. Physical examination revealed a bladder outlet obstruction due to a large paravaginal/broad ligament mass. Magnetic resonance imaging (MRI) demonstrated that the mass was separate from the uterus which was confirmed at surgery when an isolated free-standing leiomyoma was removed.

Lower urinary tract obstruction with urinary retention due to uterine leiomyomata is usually associated with an additional factor, such as adhesions or marked retroversion, which prevents the uterus from rising up out of the pelvis permitting either direct compression of the urethra against the pubic arch or elongating or kinking of the urethra.[1] Non-uterine leiomyomas of the genitourinary tract are uncommon. They may take origin from any structure containing smooth muscle. When they arise from the bladder or in the vicinity of the bladder outlet, urinary obstruction may follow.[2,3] Leiomyomata develop during reproductive life and tend to atrophy after the menopause. They may increase in size during pregnancy and in association with oral contraception.[4] We report a case in which acute urinary tract outlet obstruction was caused by a free-standing broad ligament leiomyoma in a woman who had been receiving uninterrupted oral contraception for 16 years.

CASE REPORT

A 38-year-old black woman, gravida 1, para 1, presented with a five-day history of difficulty with micturition characterized by the passage of small amounts of urine several times daily and a sense of incomplete emptying of her bladder. She had a history of asymptomatic pulmonary sarcoidosis and was a nonsmoker. She was on oral contraception which she had used continuously for 16 years following the birth of her child. Her last routine checkup, two years prior, was reported as normal. Physical examination revealed a tender, distended bladder which was easily catheterized, draining 800 mL of clear urine. A firm, nontender, left paravaginal mass extending almost to the introitus was clearly the cause of the bladder outlet obstruction.

Preoperative examination included a chest radiography demonstrating chronic interstitial changes consistent with sarcoido-

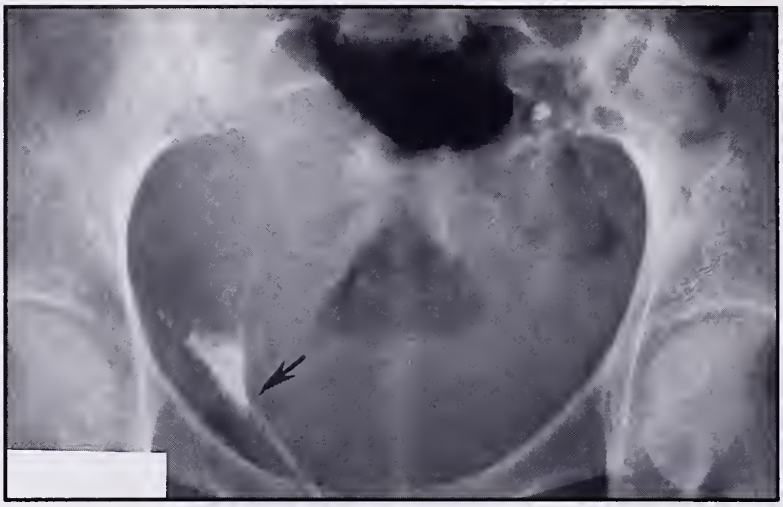


Figure 1 *- Post-void antero-posterior pelvic radiograph. Black arrow = bladder outlet.*



Figure 2 *- (a) above, Coronal magnetic resonance scan. T-1 weighted. F = fibroid, V = vagina, U = uterus. (b) below, Axial magnetic resonance scan. T-2 weighted. F = fibroid, U = uterus.*



sis. Barium enema was normal and intravenous pyelogram (IVP) showed an extrinsic mass effect on the urinary bladder with no evidence of ureteric compression (see Figure 1). Pelvic sonography confirmed the presence of a solid hypoechoic mass low in the pelvis displacing the uterus to the right and extrinsically compressing the posterior aspect of the bladder. The sonographic impression was that of a lower uterine segment leiomyoma, possibly near the cervix, however, magnetic resonance imaging (MRI) scan showed that the mass was separate from the uterus, measured 11x9x7 cm, and was consistent with a leiomyoma arising from the left broad ligament (see Figure 2). Transvaginal needle biopsy did not, however, demonstrate any smooth muscle and was reported as "a fibrosing process, either reactive-inflammatory or neoplastic."

At laparotomy, the mass was found to occupy the left paravaginal and paravesical space with no connection to the pelvic organs which were normal with the exception of some very small leiomyomata on the posterior surface of the uterus. The tumor was well circumscribed with no evidence of local infiltration. It was removed without complication and histopathology confirmed the clinical diagnosis of a benign leiomyoma which was positive for both estrogen and progesterone receptor. Bilateral Pomeroy tubal ligation was also carried out in response to the patient's request for permanent sterilization. In spite of retroperitoneal suction drainage of the large tumor bed, the postoperative course was complicated by the accumulation of a broad ligament hematoma which responded gradually to conservative management. There were no further urinary dif-

ficulties and she was healthy three months after surgery.

DISCUSSION

Complete urinary retention in the female is a rare phenomenon. Extrinsic obstruction of the lower urinary tract due to gynecologic conditions are an uncommon, but easily detectable cause of urinary retention. Generally, these disorders produce compression of the proximal urethra and bladder neck by virtue of a mass effect.[5,6] In the present instance, a free-standing, low-lying broad ligament leiomyoma occluded the lower urinary outflow tract. The tumor may have originated from smooth muscle elements in the broad ligament or as a pedunculated leiomyoma becoming parasitic and eventually independent of the uterus.[7] A vascular tumor pedicle was not identified at surgery.

Ross et al[8] investigated risk factors for uterine leiomyomas. They stated the although it is generally thought that fibroids increase in size during pregnancy, detailed studies have failed to confirm this. In addition, while case reports have suggested that oral contraceptives may play a part in the development or growth of the tumors, their study demonstrated a decreased risk. Furthermore, the risk decreased consistently with increasing duration of oral contraception. They found a roughly 17% reduction in risk with each five years of oral contraceptive use. Oral contraceptives have been implicated in the development of hepatic cellular adenomas. Marks et al[9] reported a possible association between hepatic adenomas and uterine leiomyomas. They stated that liver parenchyma is known to contain estrogen receptors and therefore postulated similar mechanisms of tumor induction by oral contraceptives for both the liver and uterus. It is generally accepted that most hepatic adenomas regress after cessation of oral contraceptives.

In view of the large size of the tumor mass, it was our original intention to administer a 3-6 month preoperative course of a gonadotropin agonist in addition to discontinuing the oral contraceptive. It was felt that removing a smaller tumor would lessen the risk of intraoperative trauma to the urinary tract and bowel as well as the risk of postoperative hematoma formation via reduction in the size of the tumor bed. However, the needle biopsy contained no smooth muscle elements and while the fibroblastic proliferation did not appear to be malignant, local infiltration could not be ruled out. Since the clinical diagnosis of leiomyoma had not been verified by the biopsy and because some form of infiltrating fibromatosis or retroperitoneal fibrosis[10] was a possibility, delay in surgery did not appear to be justified. Fortunately, the patient did well and she was spared the side effects of medical castration and the need for intermittent self-catheterization while awaiting reduction in tumor size.□

2500 North State Street
Jackson, MS 39216-4505

Supported in part by the Vicksburg Hospital Medical Foundation.

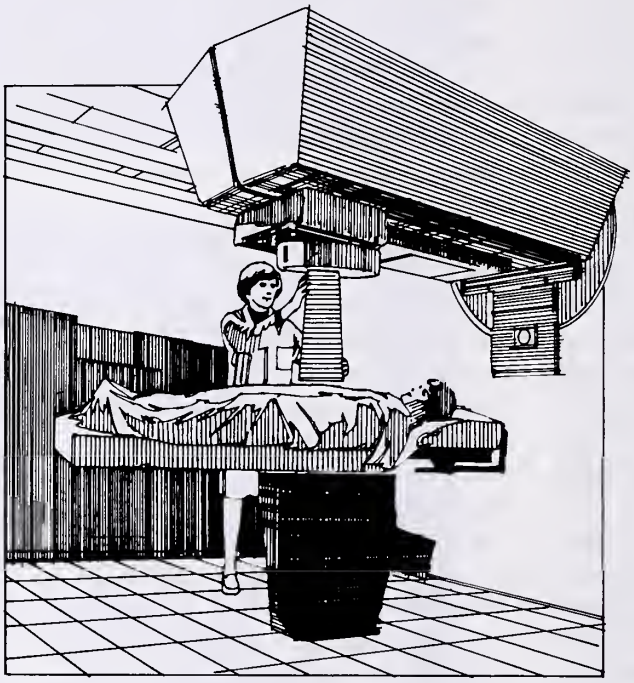
REFERENCES

1. Wood WC, Fraley EE, Marshall Jr. Postobstructive diuresis complicating relief of lower urinary tract obstruction by uterine leiomyomas. *Obstet Gynecol* 1970;35:427-431.
2. Bazeed MA, Aboulenien H. Leiomyoma of the bladder causing urethral and unilateral ureteral obstruction: A case report. *J Urol* 1988;140:143-144.
3. Brown RC, Hawtrey CE, Rose EF. Leiomyoma of vesicovaginal septum causing urinary retention. *Urology* 1975;6:379-381.
4. John AH, Martin R. Growth of leiomyomata with estrogen-progestogen therapy. *J Reprod Med* 1971;6:49-51.
5. Ward JN, Lavengood RW, Draper JW. Pseudo bladder neck syndrome in women. *J Urol* 1968;99:65-68.
6. Doran J, Roberts M. Acute urinary retention in the female. *Br J Urol* 1976;47:793-796.
7. Rader JS, Binette SP, Brandt TD, et al. Ileal hemorrhage caused by a parasitic uterine leiomyoma. *Obstet Gynecol* 1990;65:531-534.
8. Ross RK, Pike MC, Vessey MP, et al. Risk factors for uterine fibroids: reduced risk associated with oral contraceptives. *Br Med J* 1986;293:359-362.
9. Marks WH, Thompson N, Appleman H. Failure of hepatic adenomas (HCA) to regress after discontinuance of oral contraceptives. An association with focal nodular hyperplasia (FNH) and uterine leiomyoma. *AnnSurg* 1988;208:190-195.
10. Stovall TG, Ling FW. Retroperitoneal fibrosis presenting as an abdominopelvic mass. *Obstet Gynecol* 1988;71:482-483.

Dr. Rivlin is Associate Professor, Department of Obstetrics and Gynecology, University Medical Center; **Dr. McGehee** is Assistant Professor, Department of Obstetrics and Gynecology, University Medical Center; **Dr. Patel** is Associate Professor, Department of Radiology, University Medical Center; and **Dr. Meeks** is Professor, Department of Obstetrics and Gynecology, University Medical Center, Jackson.

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Evaluation of Mammographic Stellate Lesions

W. MEL. FLOWERS, JR., MD
CYNTHIA I. POWERS, MD

Primary breast carcinoma classically presents as an ill-defined mass on mammography. Frequently, there will be a central density with radiating spicules. Gross examination of these tumors reveals a firm, white, gritty center with tendrils radiating into the adjacent breast tissue. The result of mammography is a stellate mass, a lesion that once detected, has a high positive predictive value for malignancy.

The stellate mass is only one of several different radiographic signs that alert the radiologist that there may be a malignancy present. The signs also include a circumscribed mass, skin thickening, nipple retraction, a newly developing density, an asymmetrical density, ductal dilatation, architectural distortion, and abnormal calcification. The present discussion will be limited to the evaluation of the stellate mass.

DETECTION

Perception of the stellate lesion may actually be a greater problem than analysis. It may be much more difficult to find the abnormality than to decide what to do about it. The breasts are composed of fibroglandular tissue that can be quite dense. This normal tissue can obscure lesions. Confluent strands of fibroglandular tissue can also mimic a stellate lesion, suggesting an abnormality where none exists. These pseudolesions can be differentiated with compression spot films.

Nowhere in radiology is meticulous attention to technique more important than in mammography. The patient must be properly positioned. The films must be properly exposed. The films should be developed with a dedicated or modified automatic processor that extends the time in the developer to increase the contrast of the study. Quality control must be a daily concern. No amount of skill can properly compensate for poor quality films.

Once high quality radiographs have been produced, there are additional factors that can improve the detection rate. Viewing conditions must be given serious consideration. There should be a low amount of ambient light in the room. Even more important, the film should be properly masked so that stray light from the view box does not reach the eyes. These simple but highly important details should not be neglected; they considerably improve the ability to perceive lesions.

If older mammograms are available, critical comparison will sometimes reveal a developing density: a new lesion or a lesion getting larger with time. The change, or even the density itself may not be properly appreciated with only the current study.

The mammograms should be properly hung on the view box so the mirror images are compared: right vs. left if only the single study is available; old vs. new if there are previous films. Then a systematic critical comparison should be made with and without a good magnifying glass.

ANALYSIS OF THE STELLATE MASS

Once a stellate mass is detected, radiological diagnosis can be highly accurate. Not all stellate lesions are malignant, but almost

all will require biopsy. A stellate lesion consists of a center and a radiating structure.

A malignant stellate lesion such as scirrhous carcinoma (infiltrating duct carcinoma) has a distinct central tumor mass and sharp dense radiating lines of variable length. Two benign lesions that can present as stellate lesions are traumatic fat necrosis and radial scar. The center of these benign lesions usually lacks a solid dense central tumor mass proportional to the length of these spicules. Also, the spicules are of lower density than in carcinoma. The spicules of a radial scar occur in multiple bunches; those of carcinoma are more random. Both carcinoma and fat necrosis can be associated with localized skin thickening and retraction; radial scars are not. The radiographic appearance of carcinoma is constant from projection to projection; the radiographic appearance of the benign lesions may change from projection to projection. The history may be helpful in the differential diagnosis of traumatic fat necrosis. Other benign lesions may rarely present as a stellate mass including hyalinizing fibroadenoma with fibrosis.

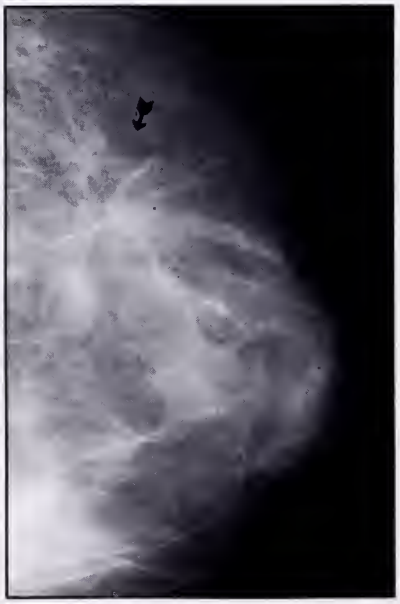


Figure 1 - Carcinoma. *The lesion has a very dense center. The radiating spicules are shorter than the mass.*



Figure 2 - Radial scar. *There is no central density or mass. Long spicules radiate from a relatively lucent center.*

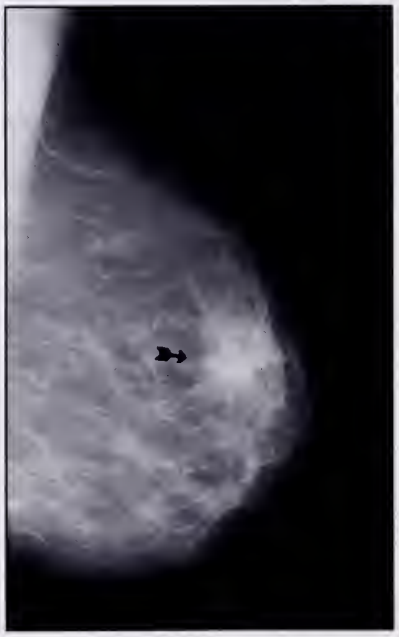


Figure 3 - Fat necrosis. *The patient had been biopsied for benign disease five months previously. There is now a stellate mass at the biopsy site, which resembles a carcinoma.*

It is important to determine that a stellate lesion can be identified on two different projections. Confluent fibroglandular tissue may simulate a stellate mass on one projection but on the orthogonal view may disperse. Spot compression views may be helpful to evaluate the central density and displace the surrounding fibroglandular tissue. Additional signs, such as architectural distortion and associated microcalcifications may suggest malignancy.

SUMMARY

Breast masses can be classified into circumscribed masses and stellate masses. Stellate masses are more difficult to detect but are easier to analyze. Good technique, proper processing, proper viewing conditions, and critical comparison of right vs. left and current vs. old can aid in the detection of stellate masses.

Once detected, analysis is straightforward. Most will be scirrhous carcinomas. A few will be radial scars, traumatic fat necrosis, or rare benign lesions. Additional signs such as architectural distortion and microcalcifications can be very important. Additional views, including spot compression films, may be decisive.

Not all stellate lesions are malignant, but most will require biopsy. Traumatic fat necrosis may be differentiated on the basis of history or radiographic appearance and does not need intervention. Lesions suspicious for carcinoma and radial scars should be excised and examined histologically. ❑

Dr. Flowers is associate professor of Radiology at the University of Mississippi Medical Centerand Dr. Powers is an assistant professor of Radiology at the University of Mississippi Medical Center.

Several Reasons Why

MPIC's

"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings
✔ 2. Established by Your Association	Up To
✔ 3. Savings over what you currently are paying	~~15%~~
✔ 4. Responsive to your needs	30 %
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 957-5100
(800) 748-9713

Sponsored by the Mississippi State Medical Association



The President's Page

WILLIAM C. GATES, MD

T. I. A. and F. F. H.
(Transient Ignorance & Apathy and Free-Floating Hostility)

The story is told that a medical leader was addressing a group of his medical society colleagues regarding problems that regularly confront organized medicine. In trying to keep his audience interested he posed a rhetorical question to one of the physicians on the front row - "I think the two greatest problems facing organized medicine today are ignorance and apathy. What do you think?" To which the gentleman on the front row answered, "I don't know and I don't care!" and promptly exited the room. This is a perfect example of T.I.A. -- textbook, in fact.

T.I.A. is a devastating and deadly disease, especially when it breaks out in a medical society. We have all seen its horrendous effects and can recognize it immediately - the frothing at the mouth, the incoherence and the loud, reverberating vituperations and invectives piled up on anyone close at hand. The frustration that heralds the onset is the clue that the free-floating hostility may not be far behind. When that occurs, the individual then assumes all of the characteristics of a "loose cannon" and his actions and behavior have the identical impact of coyotes howling at the moon.

Too often in the past our residual pioneer spirit and the free-floating hostility have combined to result in another type of very peculiar behavior - i.e., circling the wagons and then proceeding to shoot inward - usually at anything that moves, moans, groans or even stands still and just "looks suspicious."

My counterpart in the Medical Association of the State of Alabama, Dr. Peter W. Morris, feels there is a definite, predictable pathogenesis in the production of physician free-floating hostility:

"First, complacency - we're in complete control of everything;

Second, apathy - when our complacency is shocked by a rude encounter with reality, leading to the conclusion that somebody fouled up somewhere; the situation is hopelessly out of control, and so we can turn our backs to the problem and forget it;

(Continued on page 363)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 10
OCTOBER 1992

Sports Page Medicine

A recent sports page editorial in the *Clarion Ledger,* titled "A tale of 2 surgeries: It was the best and worst of (recovery) times", reflects inappropriate journalism by the two staff writers responsible for the article. "This is a story of two football players, two appendectomies and two different recovery periods."

One patient had laparoscopic surgery while the other had a conventional procedure. To the lay public this article strongly suggest that laparoscopic appendectomy is the only way to have such an operation and that other surgical methods are out of vogue and lead to prolonged recovery, causing a delay in returning to sporting activities. The names of the surgeons involved were published with the writers stating that one of the surgeons wouldn't comment on his case, giving an impression that he had something to hide. Apparently the staff writers know nothing about medical confidentiality laws.

The sports section of a local newspaper is not the place for anyone to discuss such matters and particularly to imply to the lay public that any one method of surgery is superior to another. These matters are best left to surgeons who consider multiple factors, when evaluating any given patient, to determine which surgical procedure is best for that patient. One of the least important considerations should be how soon a patient could return to the football field.

Laparoscopic surgery is only one method of doing an appendectomy and it is clearly not indicated in all patients.

Such articles of sports page medicine discussing laparoscopic surgery, arthroscopies, or any other surgical procedure is clearly not needed by the citizens of this state.

Myron Lockey, MD
Editor

Presidents's Page

(Continued from page 362)

Third, hostility - we tried not to care because they've messed everything up but now they've really made us mad; a plague on all their houses - in fact, on everybody's house."

He goes on the say, "Unless anger is channeled, it is little better than defeatism. You can bellow like a bull in the doctor's lounge or at a cocktail party, making the heavens rattle with your rage, but if that's the end of it, if you have nothing to contribute to remedial actions, you have accomplished no more than the less demonstrative physician who sulks quietly in his tent."

The free-floating hostility is indiscriminately destructive in its undirected, unchanneled form and doesn't recognize a friend - foe boundary. How to harness hostility? Just imagine - focusing all that pent-up energy like a huge laser and vaporizing some of our more formidable problems and hassle-factors and

(continued on page 364)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Presidents's Page

(Continued from page 363)

perhaps even spilling over to affect public policy and purpose, pointing to the pathway of breaking the political and social grid-lock of the present.

The treatment, in fact the cure, of T.I.A. and F.F.H. is not complex and it won't take long to note decided improvement in all ramifications of the diseases. The cure coincides with an action plan - get informed, get involved, get invested - in your personal and professional future.

The simplest thing you can do to help is to be a member of your local, regional, state and national medical associations - if you feel you can't give your time and talent, the least you can do is share the cost of the many efforts going on in your behalf. The next thing you can do is to support your PACs financially - both MMPAC and AMPAC. And, finally, get involved and give your time, energy and intelligence to politics and to projects that serve the common good.

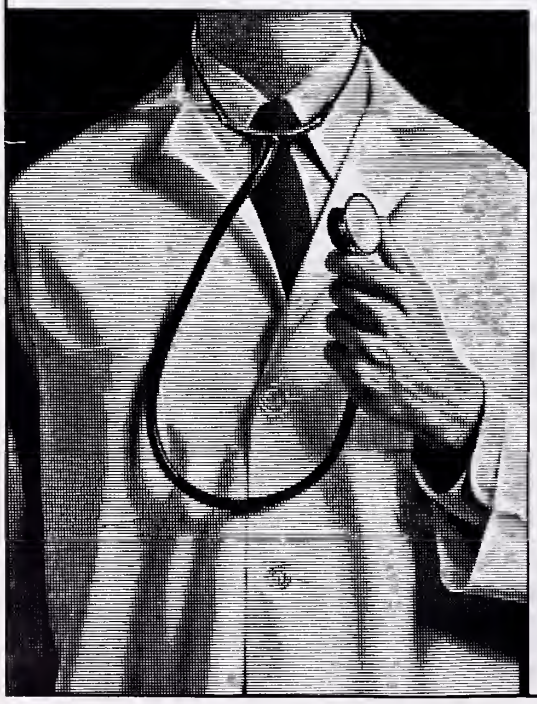
This election year is likely the most crucial for organized medicine than any ever before - both on the state and national levels. If you are uncertain where a candidate stands or which candidate your PACs are supporting, call 1-800-898-0251 and discuss it with Clare Hester, our very capable Director of Legislative Activities. She can usually tell you who our friends are and who's not. Call the candidates you are going to support and let them know. Volunteer to help in some way (you can choose the level of involvement). When Clare goes to see them later during the course of legislation your investment of time and effort will pay dividends and help her work in our behalf.

Help eradicate T.I.A. and F.F.H. in our profession!

I hope my note finds you and yours doing well ...

Best regards,
Bill

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect .

ARMY HEALTH CARE TEAM
(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.

Letters

Dear Dr. Johnson:

I am writing to compliment you on the fine editorial you have written for the Journal of MSMA. I don't think the Pryor legislation is well understood by Mississippi's physicians or Mississippi's congressional delegation.

We have applied for funds to contract for some academic detailing to rebut the drug companies' messages in an effort to reduce unnecessary costs to the Medicaid program. I hope to be writing more about that later.

Thank you for your assistance to the Medicaid program.

Sincerely,

Helen Wetherbee, JD, MPH
Director, Division of Medicaid
Office of the Governor

To: The *MSMA*

I have reviewed the August Journal and the MSMA report that you sent to us and wanted to express my appreciation for the articles on Medicaid drug cost. I truly feel that the prescribing physician is the key to controlling this cost and that without their cooperation, severe restrictions and reductions in services covered by Medicaid are just around the corner.

Again, thanks for your help.

Sincerely,

Will Lowery, Deputy Director
Divison of Medicaid
Office of the Governor

FOR INVESTMENT PERFORMANCE - WE'RE #1

33.3%* AVERAGE ANNUAL NET RETURN FOR PAST 5 YEARS

*MONEY MANAGER REVIEW RANKS CAMBRIDGE EQUITY ADVISORS THE **#1** PERFORMING MONEY MANAGER IN THE COUNTRY THE PAST FIVE YEARS

*AN INITIAL **$100,000** INVESTMENT ON OCTOBER 21, 1985 WOULD BE WORTH **$643,824** THROUGH MARCH 31, 1992

*INDIVIDUALLY MANAGED PORTFOLIOS HAVE INCLUDED STOCKS LIKE HOME DEPOT, U.S. SURGICAL, AMGEN AND WAL-MART

*WE MANAGE PERSONAL AND RETIREMENT ACCOUNTS AND CAN PROVIDE PHYSICIAN REFERENCES UPON REQUEST

CALL OR WRITE FOR MORE INFORMATION

CAMBRIDGE EQUITY ADVISORS

5214 MARYLAND WAY, SUITE 309, BRENTWOOD, TENNESSEE 37027

(800) 426-1391 (615) 371-9002

RATE OF RETURN IS CALCULATED ON TIME-WEIGHTED BASIS AND IS NET OF ALL FEES AND COMMISSIONS. RESULTS INCLUDE REINVESTMENT OF INCOME. RETURNS PRIOR TO JAN 1, 1990 FROM AUDITED MODEL PORTFOLIO AND THOSE AFTER THIS DATE ARE ACTUAL ACCOUNTS MANAGED OVER $100,000. PAST PERFORMANCE IS NO GUARANTEE OF FUTURE CONTINUED PERFORMANCE.



Photo courtesy of the Mississippi Department of Economic and Community Development.

Placid. Peaceful. Protected.

Putting your mind at ease so you can concentrate on providing the best health care for your patients. As the nation's largest doctor-owned, doctor-managed professional liability insurer, The Doctors' Company works with over 16,300 member physicians, helping them reduce losses and improve patient care.

We're here to protect the professional environment of Mississippi physicians. The Doctors' Company is helping good doctors practice better medicine.

If you're not already a member, call The Doctors' Company today.

(800) 898-0373

THE DOCTORS' COMPANY

The Doctor-Owned. Doctor-Managed Professional Liability Specialists.

Represented in Mississippi by: Sampson Howard & Ashcraft
Bill Howard
(800) 530-7598 (National) • (601) 956-3720

"Current Opinions"

of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON PRACTICE MATTERS

Use of Restraints

All individuals have a fundamental right to be free from unreasonable bodily restraint. Physical and chemical restraints should therefore be used only in the best interest of the patient and in accordance with the following guidelines:

1. The use of restraints, except in emergencies, may be implemented only upon the explicit order of a physician, in conformance with reasonable professional judgement.

2. Judgement should be exercised in issuing pro re nata (PRN) orders for the use of physical or chemical restraints, and the implementation of such orders should be frequently reviewed and documented by the physician.

3. The use of restraints should not be punitive, nor should they be used for convenience or as an alternative to reasonable staffing.

4. Restraints should be used only in accordance with appropriate clinical indications.

5. As with all therapeutic interventions, informed consent by the patient or surrogate decisionmaker is a key element in the application of physical and chemical restraints, and should be incorporated into institutional policy.

6. In certain limited situations, it may be appropriate to restrain a patient involuntarily. For example, restraints may be needed for the safety of the patient or others in the area. When restraints are used involuntarily, the restraints should be removed when they are no longer needed. ❑



THERE *IS* INSURANCE FOR THE UNINSURABLE.

You see them most every day — patients who, because of an injury, chronic illness or congenital disease, cannot find an insurer to cover their medical expenses. They are left to pay their bills any way they can. It's a burden on them. It's a burden on you.

Now there is a solution.

The Mississippi Comprehensive Health Insurance Risk Pool Association offers a comprehensive major medical benefits plan to Mississippians who can otherwise afford insurance but are unable to obtain it due to health conditions.

Operational since January, 1992, the policy offered by the Risk Pool Association contains a maximum benefit of $250,000 and a choice of yearly deductibles of $1,000 or $2,000. There is a one-year pre-existing condition limitation.

You can make a difference.

Since the program is new, its benefits are not widely known. You can help spread the word. If you have patients who cannot obtain health insurance because of injury, chronic illness or congenital disease, have them contact their local insurance representative or the Risk Pool Association. The Association benefit plan is administered by Blue Cross & Blue Shield of Mississippi.

If you have any questions about the Mississippi Comprehensive Health Insurance Risk Pool Association, call Lanny Craft at **(601) 362-0799.**

MISSISSIPPI
COMPREHENSIVE
HEALTH INSURANCE
RISK POOL ASSOCIATION

P.O. Box 13748 • Jackson, MS 39236-3748

Medical Organization

Dr. Cobb Receives Public Health Association Award for Excellence



State Health Officer Dr. Alton B. Cobb will receive the American Public Health Association's Award for Excellence at the annual meeting in Washington, D.C.

APHA's 120th annual meeting and exhibition will start November 8 and continue through November 12. The award, one of the four major Association wide honors, will be presented at the November 10 Leadership Recognition Banquet.

The Award for Excellence goes annually to a living person in recognition of his/her "exceptionally meritorious contributions to the improvement of the health of the people. It honors creative work of particular effectiveness in applying scientific knowledge or innovative organizational work to the betterment of the community health."

The award honors Dr. Cobb for having "contributed significant lifetime service to improvement of the public health in his native state and throughout the nation. Colleagues call frequently for his perspective, vision, and testimony in assessment, policy development, and assurance of delivery of health promotion and disease prevention services."

"His reputation is both hard-earned and well-deserved," declared nominators Betty Jane Phillips, Dr.P.H., and Nancy Kay Sullivan, M.P.H. "Dr. Cobb built his public health career on the belief that the public health system should put its highest priority on prevention and protective health services and that all people should have access to primary health care services, with the emphasis on disease prevention and health promotion."

To that end, when first appointed Mississippi State Health Officer in 1973, he reorganized the state's public health agency. He instituted a district management system for county health departments to foster local decision-making, facilitate policy development and implementation, and increase program coordination, thereby improving strength and efficiency of service delivery. Mississippi pioneered integration of services at county health departments, representing a major departure from the traditional categorical service delivery system.

Phillips and Sullivan cited Dr. Cobb's special contributions in creating the Mississippi WIC Program, in spearheading efforts to reduce the infant mortality rate and to modernize Mississippi's public health statutes, in pushing for compulsory school immunization and now immunization of two-year-olds, in guiding development of a statewide emergency medical services system, and in achieving major expansions in the broad and complex area of environmental health.

"But Dr. Cobb's not resting on those accomplishments," they affirmed.

Addressing the Association of State and Territorial Health Officials at their 1991 meeting, Dr. Cobb declared, "Our greatest opportunity ever lies just ahead. We must incorporate public health priorities into the new fabric of American health care.... build strong partnerships and coalitions for change that can institutionalize public health values and priorities." ❑

Dr. Segars Honored For His Efforts

Tenacity, dedication and vision were among the qualities attributed to Dr. Kelly S. Segars and were cited as reasons the Aerospace Business Center in Iuka, MS was dedicated to him.

Herman Vanderheyden, owner of Vanderheyden Construction Co. and president of American Investment and Development Corporation said that it was only appropriate to dedicate the building to someone who made the building a reality.

"The reason we were given the opportunity to perform this feat was largely due to the tenacity and persistence of one man, a man who convinced NASA, Lockheed and Aerojet to give Iuka, MS a chance. That man was Kelly S. Segars, MD," Vanderheyden said.

The aerospace facility, in Iuka Industrial Park, is leased by Lockheed Missiles and Space Co., Aerojet Solid Propulsion, NASA, U.S.B.I. and the Iuka office of Vanderheyden Construction Company. The buildings house over 800 employees.

U.S. Senator Trent Lott, R-MS, special quest speaker at the dedication, explained that now that the Advanced Solid Rocket Motor (ASRM) project has begun he and other congressman from Mississippi have to continue to work to assure further appropriations.

"I am convinced that full funding will be approved," said Senator Lott. "One danger is if space station is scuttled because of congressional demagoguery. That will be a problem for ASRM." He said that the two projects are tied together and that he will be speaking in favor of both during congressional meetings. Senator Lott praised the accomplishments of Dr. Segars and said that too often the efforts of local people are not recognized.

Chuck Levinsky, president of Aerojet-ASRM project, explained that when his organization was searching for a building to fit their needs in the Iuka area they ran into problems. They could not find a building suitable so they began looking farther away from this area. When Dr. Segars volunteered to have a building built by their transition deadline, Levinsky admitted that he was skeptical.

"Dr. Segars assured me that it would be ready to move into on time," Levinsky said. "When I came to the ground-breaking ceremony and saw the slab poured and the building closed in, I knew that it would be finished. It was his efforts that convinced us it could be done - it would be done - and through his personal guarantee that we would be in this building by our first of June deadline. We signed up with him. We went forward ... It was absolutely through the dedication and efforts of Dr. Segars that we ended up being located in this office and I think it is eminently appropriate that this building be dedicated to him."

Dr. Segars rebutted what was said by the dedication speakers, saying "this is no one-man project." Dr. Segars thanked the many others involved in securing the facility. In way of explanation for his achievements and advice for those wishing to pursue such ventures, Dr. Segars said that he would challenge them to "take a stand! Because there is nothing in the middle of the road but a yellow stripe and dead possums." ❑



Kelly S. Segars Aerospace Business Center located in Iuka, MS.

Local Doctor/ Artist Gets Special Recognition

Dr. Edsel F. Stewart is delivering more than babies these days. An obstetrician/gynecologist in the McComb area for almost 40 years, Dr. Stewart is well known locally by the mothers he has cared for and the babies he has delivered.

Today, his recognition is from another area — the art world. His paintings can be found in private, corporate and college collections around the country. Some of his work can be seen in the Eudora Welty Library collection, the E.F. Hutton Building in Jackson and the Federal Land Bank of New Orleans.

Dr. Stewart was notified that the publication department of the American Medical Association has chosen his work to feature on season greeting cards they will publish and sell to raise money for the American Medical Association Education Fund, a fund established some 30 years ago to raise money for needy students in the medical field.

Two exquisite holiday cards featuring winter scenes by Dr. Stewart are available for your personal and professional use. These cards may be purchased through the AMA catalog of publications, products and services and are shown on page 18 of the Fall 1992 catalog. All cards ordered by November 1 will be delivered by November 28. If you do not have a catalog and wish to place an order please call the MSMA office 1-800-898-0251 and we will send you the necessary information.

Earlier this year Dr. Stewart's vivid watercolor tilted "Tulips" was featured as the cover of the program of MedArt International's 1992 World Congress on Arts and Medicine in New York City. Inside the program the two-page centerfold featured four of his works — three watercolors and an oil still-life painting of yellow pears on a black background. At the same time, his paintings were on exhibit at Cork Gallery in New York

A past president of the American Physicians Art Association, Dr. Stewart has won awards in their exhibits, including "best in show" in Orlando Florida. He earned his master in studio art from Mississippi College under the direction of Dr. Sam Gore. ❑

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Do your Retirement Plan Investments need a *Shot in the Arm?...*

Consider Medley & Company.
We access top-notch money managers through no-load mutual funds - using a proven asset allocation model - so that you can have a *healthy* retirement plan.

Call for a free brochure.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 1/800 / 844-4123



GONE ARE THE DAYS OF EXCESS.

Of free wheeling. Of winning at all costs. Of seeing just how far you can go and just how much is too much. There is tighter regulation. Investment firms are reassessing, going back to square one. The point is, investing today is serious business. And it is serious business at Deposit Guaranty Investments. Not to say we're so conservative we don't seize an opportunity when it comes along. It's that we pride ourselves on advising our clients based on solid research, and on making level-headed decisions. (no hastily-made recommendations here). So far it has proven successful. Today, while the rest of the financial world seems to be taking a step back, we are proudly taking two forward. We've expanded our investment staff to give our clients better service. We've consolidated our various investment outlets into one professional investment firm, to give our clients added convenience with very competitive commission rates. Look to us as an investment firm with integrity. One that is a trustworthy, loyal friend to thousands of investment-minded Mississippians. And rest assured, we offer the same services as more well-known Wall Street firms.

Please phone us at your earliest convenience.

DEPOSIT GUARANTY® INVESTMENTS

Member National Association of Securities Dealers • A full-service investment and securities firm •1-800-748-9991

SIPC

From the University of Mississippi Medical Center

Professorship at UMC Honoring Dr. Ralph T. Wicker

Friends and colleagues of the late Dr. Ralph Thomas Wicker of Hattiesburg have established a professorship in spinal cord injury in his name at the University of Mississippi Medical Center in Jackson.

"Ralph Wicker was a superb neurosurgeon," said Dr. Robert R. Smith, professor of neurosurgery and chairman of the department at UMC. "He also was that rare physician who truly set the standard for the rest of us--not only in the practice of medicine but in the conduct of his daily life."

Dr. Wicker was Mississippi's first neurosurgeon to establish head and spinal cord injury prevention programs geared toward adolescents. He died August 23, 1992, after a long illness. He was 54 years old.

"He modeled the program after one developed in Florida to teach children and teens the importance of practices such as buckling up, jumping 'feet first - first time' into unknown waters and the dangers of combining alcohol with driving and outdoor activities," Dr. Smith said.

From 1971 to 1982, Dr. Wicker was the only neurosurgeon practicing full-time in the multicounty area served by the Hattiesburg trauma center. Dr. Wicker's wife, the former Carrol Anne Major, is a nurse and helped her husband introduce the Hattiesburg hospital staffs to neurosurgical patient care.

"There had never been a neurosurgeon in Hattiesburg before," Mrs. Wicker said. "The program he introduced is still in operation here."

Wicker earned his baccalaureate degree at the University of Mississippi in 1960 and his MD at UMC in 1963. He did his residency in surgery and neurosurgery at the Medical College of South Carolina where he received the Upjohn Achievement Award as the outstanding surgery resident. In 1966, he interrupted his training for two years service in the United States Navy which included a year in Vietnam on the hospital ship, USS Sanctuary. He returned to South Carolina to complete his residency in 1968 and opened his practice in Hattiesburg in 1971.

Dr. Wicker served on staff at Forrest General Hospital and Methodist Hospital in Hattiesburg, South Central Regional Medical Center at Laurel and as a consultant to the Mississippi State School for the Mentally Retarded at Ellisville. He was a clinical professor emeritus at UMC.

Dr. Wicker was active in several local, state and national neurosurgical professional organizations. He served as president of the Mississippi State Neurosurgical Society and was the 1991-92 vice president of the Neurosurgical Society of America.

The Wicker Professorship will help assure that the UMC School of Medicine can recruit an outstanding physician scientist who has special expertise and special interest in spinal cord injury and spinal surgery. Gifts totalling $500,000 will endow the professorship.

"I'm pleased to know that there will be something that will enable his influence in the field of spinal cord injury prevention and care to continue," said Mrs. Wicker. "This endowment will help recruit someone who will make UMC a leader in this area." ❑

UMC Students Receive Hearin-Hess Scholarships

Thirty-two University of Mississippi Medical Center students have been awarded Hearin-Hess Scholarships for 1992-93.

They are:

Seniors: Kimberly Cranston Bergeron, Johnny Ray Bullock Jr., Michael Doherty, Mary Lipe, Robert McAuley, Hanna Mitias, Robert Pitcock and Amy Rapp.

Juniors: James Eubanks, Stacey Frohn, Martin Harvey, Richard Kennedy, David Lee, Kimberly Pope Nichols, James Underwood, George Walcott, Jr.

Sophomores: Laura Bruce, James Carter Jr., Bradford Dye III, Joseph Mardis, Marilyn McCardle, Michelle Moate, Rex Poole Jr. and Karen Bergstrom Shackelford and;

Freshman: Wendy Bowen, Jepta Cole, Catherine Cooley, Steven Easley, David Harrison Jr., Donald Jones III, Thomas Sligh and Hari Tumu.

Hearin-Hess Scholarships are awarded annually to medical students who are in good standing, rank in the upper third of their class and commit to in-state practice for at least five years after graduation.

Named for Jackson businessman, the late Robert Hearin, and Leon Hess, owner of the New York Jets, the scholarships are made possible through annual donations of $100,000 each from the Robert Hearin Foundation of Jackson and the Leon Hess Foundation of New York.

A Mississippi native, Hearin was president and CEO of Mississippi Valley Gas Co. in Jackson. Hess a long-time friend and business partner, joined Hearin in establishing the scholarships in 1988. The men shared substantial interests in several ventures including Mississippi Valley Gas, First Capital Corp., the parent firm of Trustmark National Bank, the Jets and Hess's Amerada Hess Corp., one of the largest oil companies in the world.

Hearin-Hess Scholarships pay a year's tuition and are renewable each year of medical school to recipients remaining in the upper third of their class. The scholarships also are awarded in nursing at the Medical Center. ❑

Dr. Eichhorn Represents United States On Anesthesia Task Force

Dr. John H. Eichhorn, professor of anesthesiology and chairman of the department at the Medical Center, was one of the two U. S. representatives on the ten-country task force which spent two years drafting detailed standards for anesthesia practice which were adopted and commended to component societies at the 10th World Congress of the World Federation of Societies of Anesthesiologists (WFSA).

Proceedings from the summer meeting in The Netherlands, including a discussion of the standards, will be published this fall in the *European Journal of Anesthesiologists.*

Dr. Eichhorn thinks the standards will have a great impact on anesthesia safety, especially in developing countries which will use the standards to justify better equipment and more thoroughly trained personnel.

The sanction of the task force document by the WFSA culminates a decade-long effort by Dr. Eichhorn to promote anesthesia safety--first at a local level in Boston, then nationally, and finally worldwide.

"Today, the odds of being killed in a car wreck are 50 times greater than the odds of a healthy person dying from an anesthesia accident during surgery," Dr. Eichhorn said. "Ten years ago, the odds were close to even. There's been a vast improvement."

As associate professor of anesthesiology at Harvard and staff anesthetist at Beth Israel Hospital in Boston, Dr. Eichhorn chaired the committee which examined all anesthesia accidents in the nine-department Harvard Medical School system from 1976-1984.

"We looked at every case in which a person died or suffered severe brain damage in accidents involving anesthesia," he said.

The majority of accidents reviewed seemed preventable, the committee found. And most were the result of a failure of the anesthetist to guarantee the breathing of the patient. In many cases they did not recognize an obstruction or disconnection in the breathing system or a failure of the oxygen supply early enough to prevent catastrophic results, Dr. Eichhorn said.

The committee recommended basic, but continuous monitoring of an anesthetized patient, a concept most anesthesia departments followed but had not codified.

Other recommendations were made, but for the most part, the Harvard committee focused more on the behavior of the anesthetist than on equipment.

"We called our recommendations 'standards of practice' very deliberately to emphasize the importance of constant safety monitoring," Dr. Eichhorn said.

"It was a radical idea. The medical and legal implications are profound. Calling something a standard in medical practice automatically determines that someone who ignores it has no defense."

With the Harvard anesthesiologists convinced, Dr. Eichhorn soon found himself with another assignment--a seat on the Committee on Standards of Care of the American Society of Anesthesiologists (ASA). In 1986, the ASA adopted standards for basic monitoring for the first time in its history. An earlier attempt to get the membership to endorse standards for obstetric anesthesia had failed.

Persistence and diplomacy in persuading anesthesiologists to accept and endorse the standards have paid off. Anesthesiology malpractice insurance premiums have decreased much more than premiums for any other medical specialty.

"The most dramatic decrease was in Massachusetts where, in four years, premiums have gone down 60 percent. Insurance company actuaries are not charitable people. They do not reduce premiums for one specific group unless there are fewer and less severe claims filed," Dr. Eichhorn said.

Obviously, no data with a control group can ever be obtained, but Dr. Eichhorn is convinced that "we've succeeded in reducing anesthesia accidents and made anesthesia safer overall. I feel very good about that." ◻

UMC Students Receive Ottilie Schillig Memorial Scholarships

Eight students in the School of Medicine at the University of Mississippi Medical Center have been awarded Ottilie Schillig Memorial Scholarships for 1992-93.

They are seniors Harvey Mason and Stephen White, juniors Clay Calcote and Stephen Shaw, and sophomores Todd Moore and Lane Pitts and freshman Christopher McCartney and Kimberly Gulledge.

Awarded on the basis of academic excellence, the scholarships pay a year's tuition and are renewable each year of medical school to recipients remaining in the upper two-thirds of their class.

Established in 1984, the scholarship is named for the late Ottilie Schillig, a noted concert singer and Port Gibson native. ◻

The Delta Region AIDS Education and Training Center grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN, Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street, Jackson, MS 39216-4505

MSMA-SPONSORED
Standard Insurance Claims Forms
HCFA 1500

☐ • **Old two-part snap-out, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part snap-out, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$37.25 Plus State Sales Tax**	**$45.00 Plus State Sales Tax**

☐ • **Old two-part continuous, NCR Form - 1000/carton**

or

☐ ★ **NEW two-part continuous, NCR Form - 1000/carton**

Number of Cartons Requested	Member Price Per Carton	Non-Member Price Per Carton
☐	**$39.00 Plus State Sales Tax**	**$47.00 Plus State Sales Tax**

- **All orders plus 7% Mississippi Sales Tax unless your organization is tax exempt**
- **Price includes all delivery and handling costs**
- **Rapid Shipment via UPS**

ORDER INFORMATION

RETURN ORDER BLANK TO:

Order Department - Insurance Forms
Mississippi State Medical Association
PO Box 5229
Jackson, MS 39296-5229

Call in orders:

(Toll Free In-State Wats)	1-800-898-0251
Jackson and surrounding area	354-5433
MSMA Fax Number	352-4834

SHIP ORDER TO:

_____
_____
_____
_____
(Please indicate street address and zip code)

_____
(name of individual placing order)

_____
(purchase order #)

_____
(phone #)

Personals

Samuel M. Allen of Quitman has been named a Fellow of the American Academy of Family Physicians.

Frank W. Bowen of Carthage was elected president-elect of the Mississippi Chapter of the American Academy of Family Physicians during the 44th annual scientific assembly.

Edward E. Bryant of Kosciusko was elected secretary/treasurer of the Mississippi Chapter of the American Academy of Family Physicians.

Sandra F. Burford of Jackson was a guest speaker at the Academy of Family Physicians Annual State Conference in Gulf Shores, AL.

R. K. Caillouette of Picayune has been elected chief of staff at Crosby Memorial Hospital.

David Lee Clippinger of Gulfport has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Ronald Dean Davis has associated with **Lionel B. Fraser, Jr** in the Metropolitan Urology, P.A., for the practice of Adult and Pediatric Urology, St. Dominic West Medical Tower, 971 Lakeland Drive, Suite 353, Jackson.

Daniel P. Edney of Vicksburg has been elected to membership in the American College of Physicians and also is now serving on



CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

the Board of Directors for the Mississippi Division of the American Cancer Society.

Edward Dunbar Field has associated with **Wayne T. Lamar, and Neil Thomas Carstens,** for the practice of Orthopaedic Surgery and Sports Medicine, 2168 South Lamar Boulevard, Oxford.

Robert Lee Giffin of Vicksburg completed continuing education requirements to retain membership in the American Academy of Family Practice.

Charles T. Haley has associated with The Grenada Clinic for Women, P.A., specializing in Obstetrics and Gynecology, 1900 Grandview, Grenada.

John F. Hassell of Laurel was installed as president of the Mississippi Academy of Family Physicians at the organization's recent scientific assembly.

William L. Horton announces the opening of his practice in General Internal Medicine, with particular interests in preventive medicine, critical care, rheumatology and dermatology, Gilmore Medical Arts Center, Earl Frye Boulevard, Amory.

David Joe has associated with MEA Medical Clinics for the practice of Ambulatory Care Medicine and Occupational Medicine, Jackson.

Diane Little of Hattiesburg recently received certification from the American Board of Psychiatry and Neurology in the medical specialty of Psychiatry.

Ernest B. Lowe, Jr., announces

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

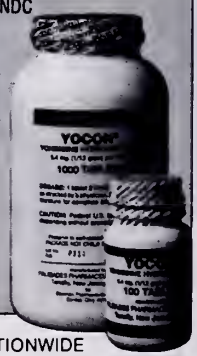
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

the relocation of his practice to Orthopaedic Surgery and Sports Medicine, Oxford Medical Building, 2000 South Lamar, Suite F, Oxford.

Aubrey B. Lucas has associated with **Chris P. Ethridge**, Hand Surgery Associates, in practice limited to Disorders of the Hand, Wrist, and Forearm, Lakeland Medical Center, 764 Lakeland Drive, Suite 404, Jackson.

Sherry A. Martin announces the opening of her medical practice of Endocrinology, The Endocrine Clinic, 812 Garfield St., Suite B, Tupelo.

Johnny F. Miles has associated with the Sanders Clinic For Women for the practice of Obstetrics and Gynecology, 1041 South Madison Street, Tupelo.

C. Troy Morrissette has associated with **H. Creed Fox** in the practice of Gastroenterology at the Gastroenterology Clinic, Wesley Towers, Methodist Medical Park, Hattiesburg.

William C. Nicholas, Associate Professor of Medicine and Chief of the Division of General Internal Medicine at UMC has recently given presentations on Endocrinology and Internal Medicine topics to medical staff officers in Jackson, MS; Fayette, LA; Jackson, TN; Monroe, LA and Natchez, MS. He has also spoken to members of the Lions Club regarding diabetes.

Shanti Pandey of Fayette has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.



"I'm practicing medicine the way I think it should be practiced, sans the paperwork and administrative overload."

Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

A pilot. A historian. A board-certified psychiatrist. Southern to a fault. Owen Brodie knows...

It's a great way to practice medicine

CompHealth

LOCUM TENENS

1-800-453-3030

Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

Send Items for the
Personals Column
to the
Editor, *Journal MSMA*
PO Box 5229,
Jackson, MS 39296-5229

Rameshkumar B. Patel, of Jackson has been named a fellow of the American College of Radiology.

Barbara J. Proctor has become an associate in Sturgis, Henderson, & Proctor, Pathology Laboratory, P.A., Jackson.

Eddie C. Starnes of Meridian, has been elected to Fellowship in the American College of Physicians (ACP).

Eugene E. Taylor an orthopaedic surgeon from Natchez, was elected president-elect of the Southern Orthopaedic Association during the Association's Annual Meeting held in British Columbia. Dr. Taylor served as SOA's state councilor from 1986-89 and most recently served as a member of SOA's Board of Trustees.

Joe Terry, III, has associated with MEA Medical Clinics for the practice of Ambulatory Care Medicine and Occupational Medicine, Jackson.

Gerald Turner has associated with the Segars Clinic, P.A., Iuka in the practice of Family Medicine with special interest in Sports Medicine, Endoscopy and Pediatrics.

Michael Weaver recently rejoined the staff of Hattiesburg Clinic in the practice of orthopedic surgery.

Dimitri A. Yanez announces the opening of his practice of Obstetrics and Gynecology, 290-B Hancock Square Drive, Bay St. Louis. ❑

Physicians' Recognition Award

Ten MSMA members were named recipients of the AMA Physicians' Recognition Award in August 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by medical society.

Central Medical Society
Robert L. Hotchkiss, MD
Henry Edward Irby, MD

Clarksdale & Six Counties Medical Society
Van Robinson Burnham, MD

Coast Counties Medical Society
Ben Judson Kitchings, MD

East Mississippi Medical Society
Dewitt Grey Crawford, MD

Northeast Mississippi Medical Society
William Gilbert Jackson, MD
Carl Chapman Welch, MD

Singing River Medical Society
William Joseph Preau, MD

South Mississippi Medical Society
John Hassell James, MD

South Central Mississippi Medical Society
Terry Earl Westbrook, MD



We Can Help You With Two Things You'd Like To Reduce: Your Malpractice Premium And Your Risks.

Now, Mississippi physicians have an opportunity to lower their malpractice insurance premiums. Doctors Insurance Reciprocal (DIR), a risk retention group owned and governed by physicians, has come to the state.

One way DIR reduces premiums is through a comprehensive, innovative risk management program. Our exclusive, proactive approaches start reducing medical malpractice risk *before* there is a problem.

We also lower premiums by offering locally based group rates for doctors who practice at eligible hospitals. Based upon the experience of local physician groups, rates have been reduced substantially.

DIR is a part of The Virginia Insurance Reciprocal (TVIR) family of companies. TVIR, which is rated A (Excellent) by A.M. Best and has assets totalling $175 million, has already won the esteem of most of the state's hospitals for its outstanding insurance service. TVIR's hospital program is a cooperative venture with the Mississippi Hospital Association, known as the Mississippi Casualty Insurance Program.

To find out more about DIR, please call B. J. Stewart in Jackson at 362-6722 or call toll-free at 800/234-8847.

DOCTORS INSURANCE RECIPROCAL

A Risk Retention Group

Placement Service

RECRUITER/MARKETER

Growing medical group seeking a highly motivated and energetic healthcare professional to manage and develop a recruitment division. Excellent communication skills and the ability to interface with physicians and hospital executives or prerequisite. This person must have 5+ years experience in management and/or marketing in the healthcare field. Advanced degree preferred.

Responsibilities include management of recruitment program and marketing recruitment services. Competitive compensation with excellent benefit package. Please send resume, salary history, and/or recent photo to: MSMA Journal, PO BOX 5229, Jackson, MS 39296-5229.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

IMMEDIATE !!!!! opening
for the right person.

If you are a **FAMILY PRACTITIONER** and are looking to have a more quality living & working environment with a **NET INCOME GUARANTEE** for the first year, take a look at what we can offer you!

Local hospital part of 16 hospital system, fully staffed and financially stable. Located between 2 recognized hospitals, in active community, with growing young families & stable economy experiencing a steady increase over the last 10 years. Fully equipped facility, offering practice support and excellent referral base.

State recognized under served area offering added income potential. For a confidential inquiry, contact **DONNA LANE, 800-362-5396, or FAX CV to 404/977-6518.**

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002,Tuscaloosa, AL 35405.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

Er Physicians Needed for North Alabama (urban communitites). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

FAMILY PRACTICE/ ER PHYSICIANS NEEDED FOR FILL-IN OR REGULAR PART-TIME BASIS AT A NORTH EAST JACKSON CLINIC. CALL 957-2273.

Items for the Placement Service should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

The advertising rate is $2.00 per line or $75.00 per 1/4 page block.
Rate cards available upon request.

FULL-TIME PHYSICIAN NEEDED. NORTH MISSISSIPPI AREA. BUSY FAMILY PRACTICE. GUARANTEE PLUS PARTNERSHIP OPPORTUNITY. (901) 753-7321.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

FP, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to POB 6002, Tuscaloosa, AL 35405.

MOONLIGHTING IN MISSISSIPPI



SINCE 1977, PRI-MED HAS BEEN STAFFING EMERGENCY DEPARTMENTS IN MISSISSIPPI, ARKANSAS, TENNESSEE, AND CALIFORNIA. PRI-MED OFFERS A WIDE RANGE OF OPPORTUNITIES FOR THE PHYSICIAN, FROM THE OCCASIONAL NIGHT SHIFT TO THE FULL-TIME EMERGENCY ROOM DIRECTORSHIP. FOR MORE INFORMATION ON MOONLIGHTING IN YOUR AREA PLEASE CALL JOE PAT JUNKIN OR PATSY MCDANIEL AT:

1-800-821-6382 - OUTSIDE TENNESSEE
1-901-685-9305 - IN TENNESSEE

Equal Opportunity Employer

PRI-MED
primary medicine

6263 POPLAR AVENUE, SUITE 700 • MEMPHIS, TENNESSEE 38119

Classified

Medical Laboratory Equipment For Sale : Hycell Counter 555 with Hct and MCV $1,000.00, Stat-Test System for glucose, pot, chol, & hgb $250.00, Junior Angle model 1600 centrifuge $150.00, #100 incubator $50.00. Call 601• 287-1453 or 601• 287-1202.

Medical clinic for a 1 to 3 physician occupancy. Equipped with supplies, furniture and instruments probably sufficient to institute immediate practice. Includes patient waiting area, 3 business offices, 9 examination rooms, 3 treatment rooms, lab, x-ray, staff lounge and storage rooms. **Located in downtown Moss Point,** an industrial city of 17837, with 2 rivers, Interstate 10 and airport within city limits. Adjacent to post office, banks, pharmacy. Ample parking. Convenient to Singing River Hospital. Contact Mrs. Barrett at John Jones and Associates. 1-800-748-8650.

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captain Mike McRaney, (601) 875-9462, PO Box 999, Biloxi, MS, 39533.**

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

NORTH MISSISSIPPI AREA. BUSY. WELL ESTABLISHED FAMILY PRACTICE FOR SALE. (901) 465-6008. AFTER 5 P.M., (901) 465-5463

Items for the Classified Section
should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.
The advertising rate is $2.00 per line or $75.00 per 1/4 page block.
Rate cards available upon request.

Index to Advertisers

Cambridge Equity Advisors 365
CancerPay Plus 358
CompHealth 379

Deposit Guaranty Investments 372
Disability Determination 382
Doctors Insurance Reciprocal 381

Eli Lilly & Co. - Humulin ..... **fourth cover**
Employer Plus, Inc. ..... **6 & third cover**

Medical Assurance Co. of MS **8**
Medley & Company 371
MS Comprehensive Health Insurance Risk Pool Association 368
MS Emergency Association 382
MS Physicians Insurance Company 361
MSMA Benefit Plan & Trust ..... **second cover**

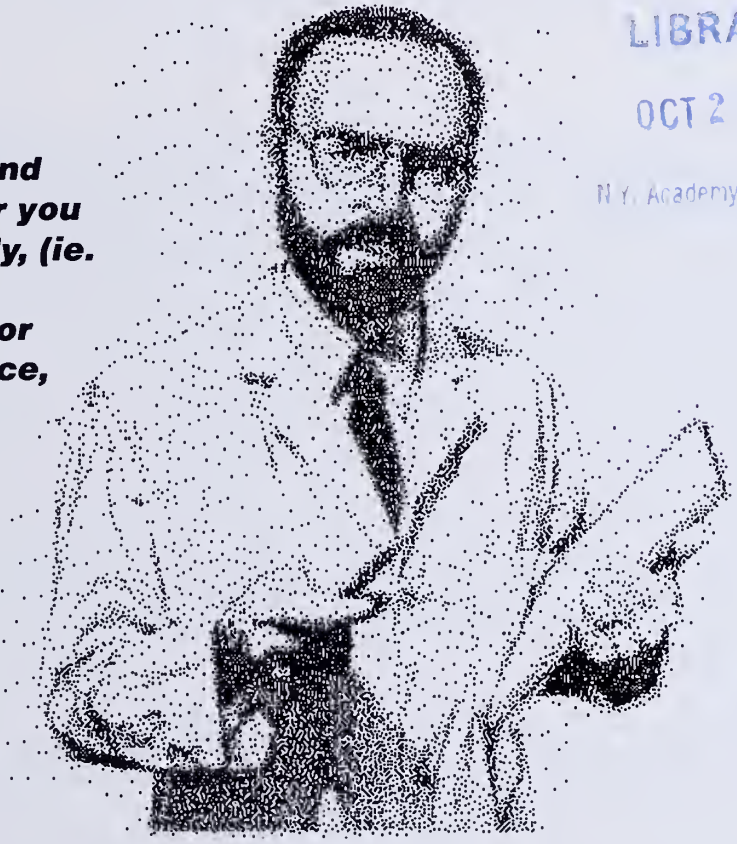
Palisades Pharmaceuticals, Inc - Yocon 378
Premier Printing 371
PRI-MED, Inc. 383

The Doctors' Company 366
Trustmark 367

US Air Force 377
US Army Active 364
US Army Reserve **4**

What can Employer Plus do for me personally, as a doctor?

LIBRARY
OCT 2 7 1992
N.Y. Academy of Medicine



For every dollar you spend on benefits for you and your family, (ie. health dental, disability, life or vision insurance, as well as dependent care or medical costs) we can save you at least 38 cents in Federal and State taxes on each dollar you are currently spending.

The choice is yours, do you continue to pay your money to the government or do you put more money in your pocket? Contact Employer Plus today, we'll discuss all the details on a personal and confidential basis. Call us

Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

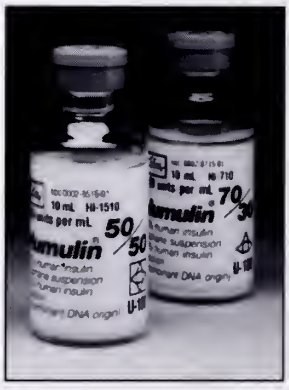
© 1992 Employer Plus. All rights reserved.



Because One Size Doesn't Fit All...

New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30®, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.



***New* Humulin® 50/50**

50% human insulin isophane suspension
50% human insulin injection (recombinant DNA origin)

The Newest Option in Insulin Therapy

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

*Humulin® 70/30 (70% human insulin isophane suspension, 30% human insulin injection [recombinant DNA origin]).

Lilly

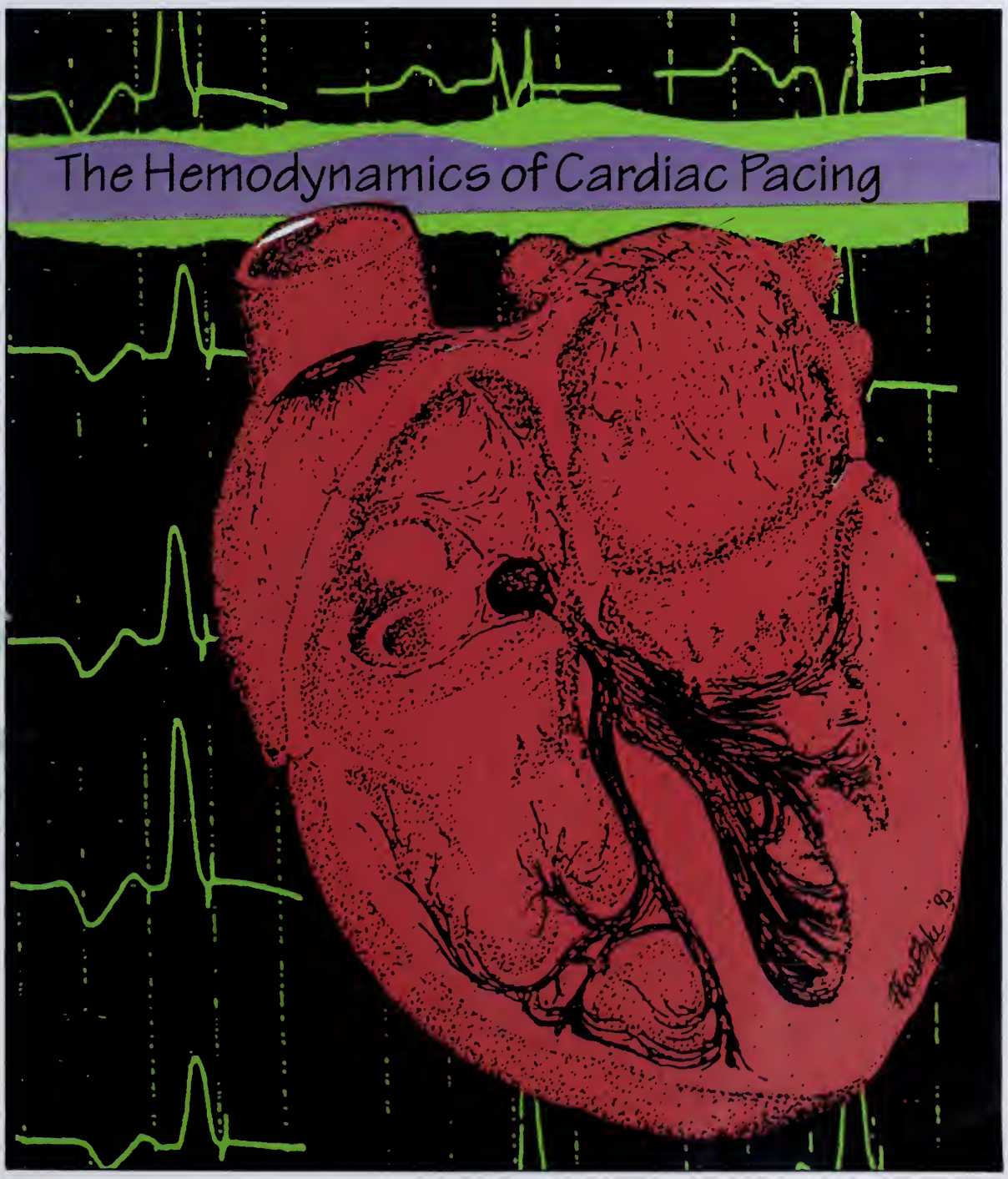
Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

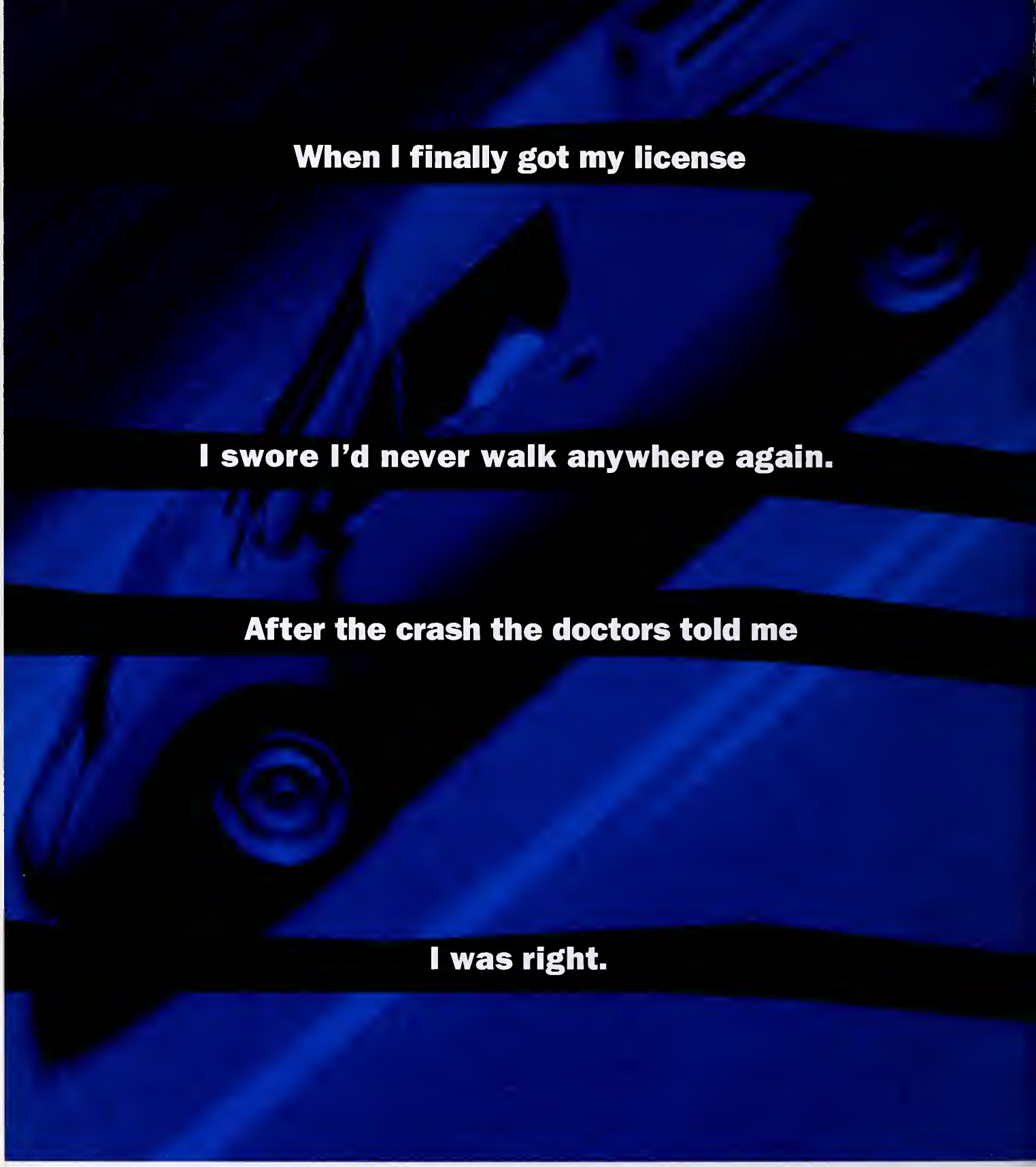
HI-7911-B-249343 © 1992, ELI LILLY AND COMPANY

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

NOVEMBER 1992





Thousands of young people suffer traumatic brain and spinal injuries in automobile accidents each year. Injuries that we could have helped prevent. But we need *your* help. Call MMRC today at 1-800-223-6672. Ask us about our safety awareness program. The information we'll send is free. And the life it could save is priceless.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

NOVEMBER 1992 VOLUME XXXIII NUMBER 11

SCIENTIFIC ARTICLE

Why *Not* Simple Ventricular Pacing? The Hemodynamics of Cardiac pacing for Noncardiologists 385

F. Earl Fyke, III, MD, FACC, FACP

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
Leslie E. England, MD
and the editors

THE ASSOCIATION
William C. Gates, MD
President
Don Q. Mitchell, MD
President-Elect
D. Stanley Hartness, MD
Secretary-Treasurer
H. Vann Craig, MD
Speaker
Eric A. McVey, III, MD
Vice Speaker
Charles L. Mathews
Executive Director

EDITORIALS

Sovereign Immunity (*res ipsa loquitur*) 394

William C. Gates, MD

Media Managed Politics and Medical Care 395

Joseph E. Johnston, MD

DEPARTMENTS

Letters 397

Current Opinions 399

Medical Organization 401

From the University of Mississippi Medical Center 404

New Members 407

Personals 411

Placement Service 418

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

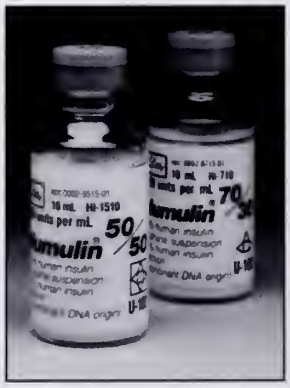
JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6396) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.



Because One Size Doesn't Fit All...

New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30*, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.



New Humulin® 50/50

50% human insulin isophane suspension
50% human insulin injection (recombinant DNA origin)

The Newest Option in Insulin Therapy

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

*Humulin® 70/30 (70% human insulin isophane suspension, 30% human insulin injection [recombinant DNA origin]).

Lilly

Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

HI-7911-B-249343 © 1992, ELI LILLY AND COMPANY

Newsletter

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 11

November 1992

Dear Doctor:

The MSMA 125th Annual Session will be held April 28 - May 2, 1993 at the Royal d'Iberville Hotel, Biloxi. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or FAX this information to (601) 352-4834. The letter requesting exhibit space should include the following information:

(1) the title of the exhibit;
(2) the author(s) of the exhibit;
(3) an estimate of the amount of exhibit space needed; and
(4) a brief synopsis of the subject to be exhibited.

***

Two nationally recognized victim advocates will join more than 200 professionals from the social services, health care, legal, and law enforcement fields when Mississippi's first statewide conference on Domestic Violence is held in Natchez October 29-30.

The conference — **Making Victims a Priority** — is being coordinated by the Mississippi State Coalition Against Domestic Violence. Keynote speakers at the conference are National Organization for Victim Assistance Executive Director Marlene Young and Anne Seymour, director of Communications and Resource Develpment, National Victim Center.

In Mississippi, more than 11,000 women contacted a domestic violence hotline in 1991. In one year -- October 1990 through September 1991 -- 771 Mississippi women sought help in coping with the trauma of rape from the state's six Rape Crisis Centers.

***

The MSMA
Socio-economic and Legislative Forum
January 19, 1993
Ramada Coliseum Hotel
Jackson, Mississippi

WINTER CME
ST. DOMINIC

Silver King Hotel
Park City, Utah
January 29, 1993 - February 3, 1993

A Multi-Speciality Conference

Topics to be addressed are:

- Orthopedic procedures
- Menopausal symptoms
- ARDS, AIDS
- Silicone breast implants
- Biliary tract disease
- Health care issues of the '90s

12 hours of Category I CME credit available

Sponsored by
St. Dominic - Jackson Memorial Hospital
Jackson, Mississippi

For More Information Call: (601) 364 - 6846

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 11

State Board of Health Meets In October

Jackson, MS — Mississippi State Board of Health will consider eight different sets of rules and regulations at their October meeting. Full agendas are available for review at the Office of the State Health Officer, State Department of Health.

Four new appointees and reappointed State-At-Large Member Frank Genzer of Biloxi will participate. Governor Kirk Fordice appointed Shelby C. Reid, MD Corinth; James V. Ferguson, MD, Greenwood; Dott Dillard Cannon of Brookhaven; and William K. Ray of Hattiesburg to represent Congressional Districts I, II, IV, and V, respectively. Their terms began July 10, 1992, and will expire July 1, 1998.

Don Felts of Greenwood serves a Board chairman. Other members are Linda Joy Gholston, RN, Tupelo; Frances (Mrs. Thomas) Coleman, PhD, Ackerman; James E. Wells, Monticello; Eddie W. Logan, Durant; Maurice James, MD, Jackson; Vertye W. Caples, Gulfport; and Cynthia S. Pace, Amory.

Along with rules and regulations that govern emergency medical services and reportable diseases, the Board will consider three sets of environmental health and three sets of child care and special licensure rules and regulations.

Environmental health rules up for consideration cover individual on-site wastewater disposal systems; the production and sale of milk and milk products, and radiation control. In the child care and special licensure arena, Board members will focus on voluntary registration of family child care homes, speech-language pathology/audiology aids, and physical therapists and PT assistants.

The agenda also includes a discussion about sovereign immunity, the FY 1993 budget request, personnel and financial reports, an update on the Home Health Services Program, and revisions to the Board's bylaws.

Flu Shots Encouraged

Jackson, MS — 788 Mississippians died last year from influenza and its most common complication pneumonia. Influenza coupled with pneumonia continues to be one of the top five causes of death in people 65 years of age and older.

The Mississippi State Department of Health (MSDH), with support from the Mississippi Chapter of the American Lung Association, encourages Mississippians to get the influenza vaccine and protect themselves against the virus.

This year Medicare won't pay for the flu shot. For the past two-years Mississippi was one of 20 states participating in a Influenza Demonstration Project, which paid for the shots. The project goals were to get high risk populations immunized and encourage cooperation from doctors and nurses to increase immunization levels.

Project sponsors will present the trial study's results to the United States Congress this year. Congress will decide whether the study proved effective enough to warrant making flu shots a standard part of Medicare coverage.

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



Medical Assurance Company has proven time and again the benefits of affiliation with a company dedicated to Mississippi physicians. Doctors don't want decisions regarding their practice made by people they have never met with offices thousands of miles away.

When actuarial consultants advised MACM that it might be necessary to raise premiums for pediatricians due to claims losses, the Company spearheaded a mandatory statewide Risk Management Program to address the problem.

By working with us, they were able to reduce losses among pediatricians, thereby avoiding rate increases which would have had a negative impact on health care throughout the State.

MACM insures more Mississippi physicians than any other company for good reason -- they *are* Mississippi physicians. Who could know our needs better?

Dr. Elizabeth Keeling is a Board Certified Pediatrician practicing in Jackson, Mississippi.

MEDICAL ASSURANCE COMPANY OF MISSISSIPPI
1-800-325-4172 or
601/353-2000 in Jackson
735 Riverside Drive ■ Suite 307
Jackson, MS 39202

Why *Not* Simple Ventricular Pacing?

The Hemodynamics of Cardiac Pacing for Noncardiologists

F. EARL FYKE, III, MD, FACC, FACP

For many years, cardiac pacing consisted primarily of implanting and following fixed-rate ventricular systems. While this mode of pacing restored a more acceptable rate and in fact reduced mortality, prevented syncope, and brought clinical improvement in patients with acquired complete heart block, that it often failed to restore the degree of wellness provided by the normal electrical conduction sequence became increasingly apparent. This paper contrasts normal cardiac mechanics to those of simple ventricular pacing, making clear why clinical outcome with the latter is often disappointing. An approach to selecting pacing modes for specific abnormalities is outlined. The legitimate role of simple ventricular pacing continues to diminish as physicians turn to more hemodynamically efficient atrial and dual chamber pacing with sensor-mediated rate modulation where appropriate.

In 1952 Zoll developed the first clinically useful, external cardiac pacemaker, which stimulated cardiac contractions with repetitive electrical impulses delivered via electrodes applied to the skin. An implantable, rechargeable device, placed by Elmquist and Senning in Sweden, followed in 1958. In 1959, American pioneers Greatbatch and Chardack implanted the first primary battery powered unit. With these early efforts, directed solely at restoring ventricular systole at an acceptable rate without regard to atrial activity, began the era of modern cardiac pacing. Initially, the use of these expensive and short lived devices was restricted to persons with acquired complete heart block, who were predisposed to frequent episodes of syncope and to sudden death because of asystole and potentially lethal ventricular arrhythmias precipitated by their chronic bradycardia. And, early experience showed that simple ventricular pacing at a fixed rate significantly decreased the incidence of sudden death in patients with acquired complete heart block. However, as the use of pacemakers became more widespread and the indications for their use expanded to include less malignant forms of bradycardia (sinus node disease is now the most common indication for pacing in this country), physicians recognized that fixed-rate, ventricular pacing failed to restore to many individuals the quality of life asso-

ciated with the normal atrioventricular (AV) activation sequence at heart rates modulated according to physiologic need. During the last two decades, major technological developments have permitted re-establishment of AV synchrony and more recently automatic, sensor-mediated modification of pacing rate to meet varying metabolic demands. What follows is a description of the normal cardiac cycle and that which obtains with simple, ventricular cardiac pacing. This comparison makes clear why there has been such interest in moving beyond fixed-rate, ventricular stimulation to more "physiologic" pacing modes.

THE NORMAL CARDIAC CYCLE

The cardiac conduction system (figure 1) mediates the events of the normal cardiac cycle. Excitation begins with impulse formation in the sinus node. An elegant neurohumoral control system modulates the rate of sinus node discharge commensurate with the varying cardiac output requirements of daily life. From the node's impulse, an electrical wavefront spreads downward across the atria depolarizing myocardium in its path and finally exciting the AV node. Except at the AV node, the atria are isolated electrically from the ventricles. A delay occurs as the impulse traverses the AV node. Then, rapid conduction through the His bundle and bundle branches into the uninsulated distal Purkinje fibers produces simultaneous depolarization of right and left ventricles. The electrical signals mediating the cardiac cycle are not of sufficient amplitude to be visible on the standard surface ECG, which records the electrical fields produced by myocardial depolarization. Some can be examined during an invasive electrophysiologic study.

Each pair of cardiac chambers—the two atria and the two ventricles—has its own cycle of filling (diastole) and emptying (systole) orchestrated into a coordinated pumping action by the electrical signals just discussed. Arbitrarily taking the moment just before the sinus node discharges as a starting point, one would find the two atria and the two ventricles nearly filled with blood that has returned passively from the body and the lungs. The wave of electrical energy sweeping downward over the atria following sinus node discharge produces a peristaltic contraction (atrial systole) that ejects a relatively small amount of additional blood contributing about 20 to 25% of the final end-diastolic ventricular volumes in normals. Atrial systole momentarily raises the end-diastolic pressure in the ventricles just prior to their contraction. By the well known Frank-Starling law of the heart, this improves their strength of contraction increasing resting cardiac output by about 10 to 30% in normal hearts and does so without requiring elevated ventricular pressures (and hence atrial and pulmonary and systemic venous pressures) throughout diastole. The sudden rise in ventricular pressure is accompanied by a fall in atrial pressure as atrial systole is completed. This pressure reversal gently pushes the tricuspid and

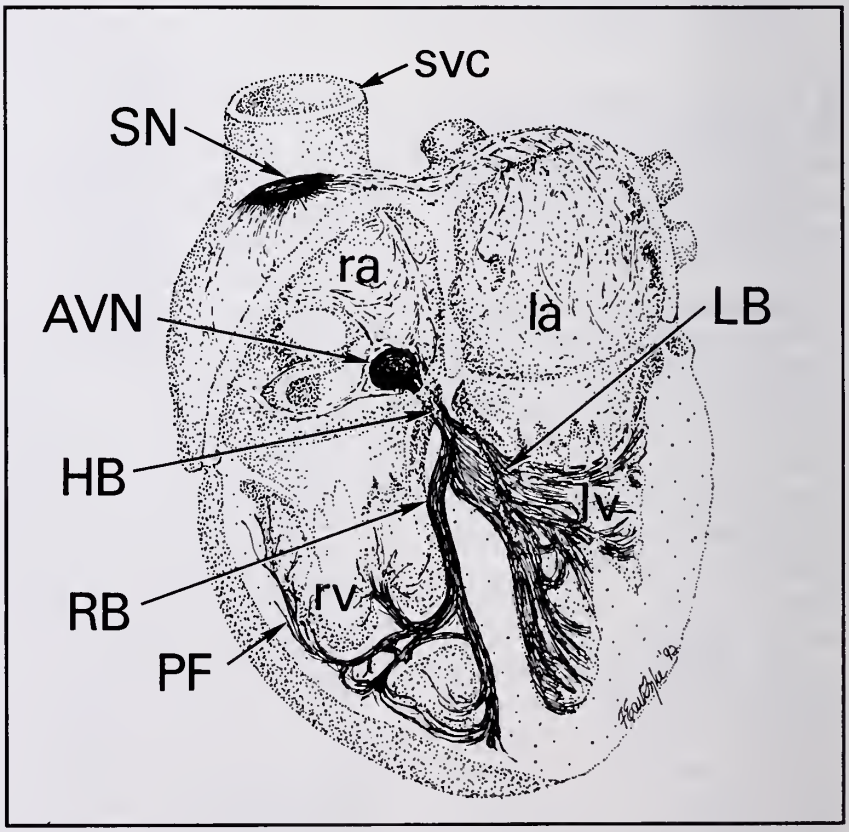


Figure 1. The cardiac conduction system. AVN = AV node, HB = His bundle, la = left atrium, LB = left bundle branch, lv = left ventricle, PF = Purkinje fibers, ra = right atrium, RB = right bundle branch, rv = right ventricle, SN = sinus node, svc - superior vena cava. Discrete conduction pathways have not been identified in the atria.

mitral valves closed prior to the beginning of ventricular contraction minimizing any tendency for tricuspid or mitral regurgitation. Proper timing of atrial contraction with respect to ventricular systole is important, particularly as heart rate increases. A PR interval in the range of 100 to 200 milliseconds has been shown to be optimal. The exact optimal value varies from individual to individual and progressively shortens with increasing heart rate.

Following the delay produced by the AV node, ventricular systole abruptly raises pressure in the ventricles closing the mitral and tricuspid valves and forcing open the pulmonic and aortic valves. A portion of the blood in the ventricles is ejected (the stroke volume). While the ventricles are contracting, the atria—isolated behind the closed atrioventricular valves—are filling with blood returning from the body and the lungs. As ventricular contraction ends and the myocardium relaxes, pressure falls rapidly in the ventricular cavities. The pulmonic and aortic valves close and the atrioventricular valves open as ventricular pressure falls below atrial pressure. Passive ventricular filling completes a cardiac cycle, and the ventricles and atria await sinus node discharge to initiate another coordinated set of chamber contractions.

To meet the varying demands of the body the normal cardiovascular system is capable of increasing output from about 5 liters/min at rest to over 20 liters/min. This is accomplished by increasing the heart rate and, to a lesser extent, by increasing the stroke volume. Normally, the PR interval progressively shortens during exercise. Loss of this physiologic modulation of the PR interval reduces the maximum cardiac output achievable with increasing rate.

THE HEART AS A PUMP DURING SIMPLE VENTRICULAR PACING

Of all pacing systems available, the simplest, least expensive, most easily implanted, and most predictably reliable is a fixed-rate, ventricular demand system. In this system's most common configuration, the paced heart is stimulated at a constant rate, frequently 70 per minute, by a single pacing lead placed transvenously so as to contact the endocardium of the right ventricular apex. The pacemaker-induced impulse spreads from the right ventricle to the left producing complexes with a left bundle branch block morphology on the surface ECG. The impulse cannot reach the atria except through the His bundle and AV node (figure 1), where it may be either conducted retrograde upward to the atria or blocked and extinguished. Retrograde conduction occurs in up to 90% of patients with isolated sinus node disease but only 15-20% of those with acquired complete heart block.[1] The response of the atria to retrograde conduction varies depending upon their state at the time of stimulation. They will contract if not refractory. In the cases of coexistent, very rapid supraventricular tachycardia, especially atrial fibrillation, the atria as well as the AV node are refractory to stimulation by retrograde conduction.

During fixed-rate, ventricular pacing, cardiac function is affected adversely in several ways: loss of AV synchrony, loss of rate responsiveness, exacerbation of mitral and tricuspid insufficiency, and sometimes by retrograde atrial activation (see below). Controversy exists as to whether the altered ventricular activation sequence of right ventricular apical pacing decreases cardiac function.[1] The only adaptation for increasing cardiac output is elevating stroke volume through obligatory increases in ventricular volumes, diastolic pressures, and sympathetic tone. Even in the absence of other cardiac disease, compensation is limited. Underlying structural cardiac disease further impairs the ability to increase stroke volume above the resting state.

The hemodynamic inefficiencies of ventricular pacing translate into physical signs and symptoms in patients dependent upon these systems. In some these are mild and even clinically inapparent (although one must wonder how much better patients so paced might feel with more physiologically appropriate pacing modes). In others ventricular pacing is disastrous. Maintenance of AV synchrony is crucial if significant mitral insufficiency is present or when ventricular compliance is decreased as in aortic stenosis, in hypertrophic cardiomyopathy, in hypertensive cardiac disease, immediately after cardiac surgery, and following myocardial infarction especially with right ventricular involvement. Patients with severe, dilated cardiomyopathy, whose stroke volumes are effectively maximized even at rest, are dependent upon rate modulation to maintain aerobic metabolism when oxygen requirements increase. Exercise tolerance falls dramatically at fixed rates. In patients with sinus node dysfunction, ventricular demand pacing appears to impose increased mortality compared to dual chamber pacing, which maintains AV synchrony.[2] Improved survival with dual chamber pacing has been

demonstrated also for patients with congestive heart failure whether presenting with sick sinus syndrome or AV block.[3,4]

RETROGRADE ATRIAL ACTIVATION AND "PACEMAKER SYNDROME"

Stimulation of atrial systole by retrograde conduction through the AV node (so-called VA conduction) is detrimental in two ways. With retrograde excitation, the atria contract shortly *after* ventricular stimulation and *during* ventricular systole when the tricuspid and mitral valves are held closed by high ventricular pressures. Inordinately high atrial pressures are produced and the pressure waves travel backward into the cavae and the pulmonary veins. This stimulates stretch receptors in the walls of the atria and pulmonary veins, which in turn produce vagal stimulation. The resultant reflex peripheral vasodilation may be marked and cause a fall in systemic blood pressure and cardiac output beyond that produced by the simple loss of AV synchrony. Unpleasant and visible venous pulsations in the neck (so-called "cannon waves"), palpitations, chest fullness, dizziness or syncope, weakness, orthopnea, pulmonary edema, peripheral edema, and hypotension are among the nonspecific but troublesome signs and symptoms experienced by 5 to 15% of patients with *normally functioning* ventricular pacemakers. A combination of these signs and symptoms, when present in a patient with VA conduction, is referred to as "pacemaker syndrome." Typical p-waves produced by retrograde activation are visible in the ST-T portion of the paced complexes in figure 2.

Pacemaker syndrome is most common in patients with retrograde atrial activation, which some authors include as part of the syndrome's definition. However, even with sinus rhythm and AV dissociation without retrograde conduction, the asynchronous atrial contractions wander in and out of ventricular systole producing cyclical variations in blood pressure, cardiac output, and at times the same signs and symptoms listed above. Because pacemaker syndrome requires effective atrial contractions, it cannot occur with chronic atrial flutter or fibrillation.

A second untoward effect of retrograde atrial extrasystoles is the induction of supraventricular arrhythmias, particularly atrial fibrillation, which is significantly more common with ventricular pacing than when AV synchrony is maintained and which leads to an increased incidence of embolic events.[5]

TOWARD MORE "PHYSIOLOGIC" PACING

In general, the better a pacing system mimics the normal state the better the recipient's heart will respond to the changing oxygen requirements of exercise and other stresses. In selecting a system for maximum clinical benefit, one should consider the following: 1) restoring/maintaining AV synchrony, 2) avoiding retrograde atrial activation during ventricular pacing, and 3) restoring/maintaining rate adaptation. Most state-of-the-art dual chamber systems now may be programmed to decrement their AV pacing intervals with increasing rates.

Restoring/maintaining AV synchrony: For the patient with intact sinus mechanism and AV block, restoring AV synchrony requires positioning a second lead in contact with one of the atria. Usually the lead is passed transvenously and the tip electrode ma-

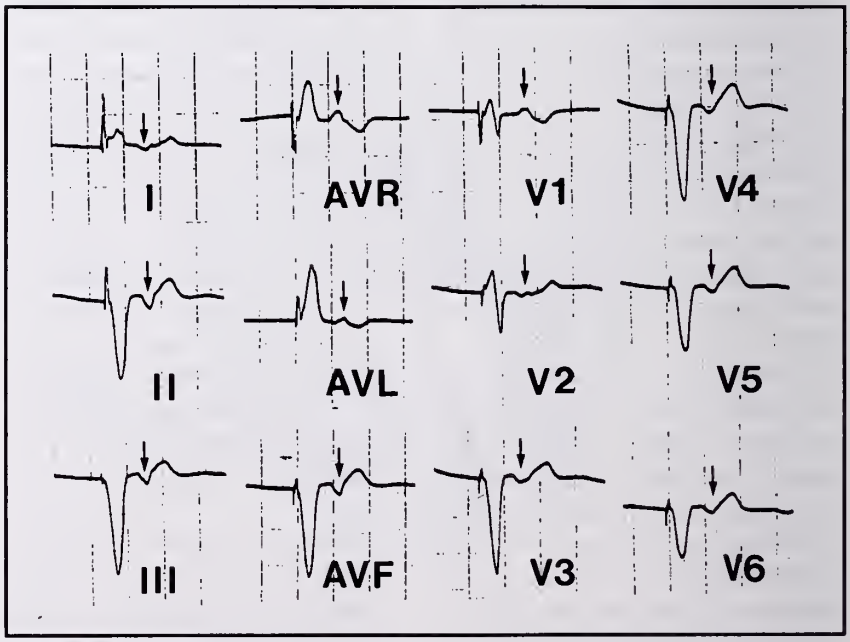


Figure 2. Paced complexes from a standard 12-lead electrocardiogram from a 78 year old woman with a ventricular demand pacemaker for sick sinus syndrome. Retrograde p waves are readily seen in most ST segments (arrows). Her chronic fatigue, dyspnea, continued syncope, and peripheral edema (pacemaker syndrome) resolved with restoration of AV synchrony by dual chamber pacing.

nipulated into the right atrial appendage thereby permitting sensing of atrial electrical activation (the atrial electrogram) or atrial pacing. The long-term functional integrity of atrial leads is well established.[6] With the two leads connected to a dual chamber pacemaker, the pacemaker's circuitry restores AV synchrony by sensing atrial systole and initiating a delay (the pacemaker equivalent of the PR interval) followed by a ventricular stimulus.

If sinus node function is inadequate (e.g., chronic sinus bradycardia), the pacing system must pace the atria. If AV conduction is intact, atrial pacing alone should be considered as it is more cost effective and technically simpler than dual chamber pacing. In properly selected patients, the likelihood of developing AV block later, which would require upgrading of the pacing system, is low. One recent review of the literature estimated the mean total incidence to be 2.1% and the mean yearly incidence 0.6%.[7] Approximately half the patients with sick sinus syndrome may be candidates for single chamber atrial pacing, while the remainder are excluded because of associated AV conduction disturbances.[8,9] If both sinus node dysfunction and AV conduction disease coexist, both atria and ventricles must be paced with the appropriate AV delay provided by pacemaker electronics.

Available dual chamber pacemakers will track the contractions of the right atrium as long as their rate is adequate but will pace the atrium if the rate falls below a programmable lower limit. A ventricular stimulus is provided, when needed, following each sensed or paced atrial event. Both atrial and dual chamber pacing systems have proven themselves to be reliable and beneficial and constitute a significant percentage of the systems implanted by most large pacing practices.

Avoiding retrograde atrial activation: The dual chamber systems just discussed only deliver a ventricular stimulus following a sensed atrial contraction or atrial pacing stimulus. Thus before, every ventricular stimulus the atria and AV node have just been depolarized and are refractory for a short time to further activation. This time period is long enough to prevent the electrical wave front of ventricular systole from echoing back to excite the atria. As a byproduct of maintaining AV synchrony, these systems prevent retrograde atrial activation. As previously mentioned, retrograde atrial stimulation cannot occur with atrial fibrillation.

Restoring/maintaining rate adaptation: Two approaches for providing rate adaptation with varying metabolic demand are available. First, for patients with AV block the atrial triggered systems just described provide rate adaptation as long as the sinus node driving the atria functions adequately. The sinus node, responding to the body's own elegant control system, is clearly superior to all other rate modulators. Although the currently available dual chamber systems are limited by technical considerations in tracking high atrial rates and may cause a number of problems of their own, they come closest to restoring "normality" to patients with intact sinus node function and AV block.

That for many the sinus node fails to provide physiologic modulation of rate either because of frank dysfunction or overriding arrhythmias such as atrial fibrillation prompted a search for other measurable parameters through which to inform the pacemaker's logic circuitry of increasing metabolic demands and the need for increased pacing rate. The most generic requirement for a sensor variable is that it change in proportion to the body's oxygen consumption under as many differing conditions as possible. The more directly and inextricably the variable is tied to oxygen consumption the better. Most interest has been directed to sensors that will appropriately modulate the pacing rate during exercise. Desirable technical attributes include simplicity of design, low production cost, low power consumption, ease of implantation, immunity from interference, long-term stability, and compatibility with previously implanted lead systems. Current candidates include a variety of derivatives from intracardiac pressures and electrical measurements, respiratory measurements computed from intrathoracic impedances, metabolic variables, and even simple body motion associated with activity.[10] Sensors currently available for use or under clinical investigation are given in Table 1, grouped according to the need for a special pacing lead. Each sensor has its advantages and shortcomings, eager advocates and equally enthusiastic detractors. Since 1986, four sensors have become available commercially in the U.S.: vibrations sensor, accelerometer, minute ventilation sensor, and central venous temperature sensor. First released only in single chamber versions, rate adaptive pulse generators for dual chamber pacing have become available within the past two years. Clinical studies have shown unequivocally that rate adaptive sys-

tems increase exercise capacity and improve patient's sense of well being when compared to fixed rate systems.[11,12] Because the sensors do not require intact atrial function, single chamber units can provide rate modulation for patients with atrial fibrillation and slow ventricular response. The response of the pacing community to this advance was so enthusiastic that the initial entry quickly became the most frequently implanted pulse generator in the world.

CONCLUSION

Increasingly complex and sophisticated pacemakers, improved and even altogether new lead systems, and innovative algorithms for rate modulation playing across the backdrop of ever increasing cost consciousness have introduced a heretofore unknown complexity to choosing the system most appropriate for an individual, to implantation, and to follow-up. While benefits of the new technologies are apparent, questions about long-term reliability of new hardware await resolution. Despite the uncertainties, skillful deployment of available systems has already improved the lives of thousands of patients. Although fixed-rate, ventricular pacing continues to have a place in clinical practice, it leaves much to be desired for active individuals who are dependent on their pacemakers for rate control. It is suboptimal, even disastrous, in the presence of certain underlying structural cardiac disorders. In some unfortunate patients, often difficult to identify prior to implantation, this mode produces pacemaker syndrome the manifestations of which are for the patients as bothersome as or worse than those of the original arrhythmia. Choosing a system for a specific patient may be difficult. The physician must critically assess the conduction problem in light of any cardiac disease present or likely to develop and then weigh in the final decision the potential benefits of complexity and adaptability, which come at increased cost, versus the desirability of simplicity, low cost, and ease of implantation and follow-up. While even astute implanters choose differently at times, that fixed-rate, ventricular demand pacing employed without forethought and careful follow-up has become unacceptable medical practice is indisputable. □

1600 N. State Street,
Suite 302
Jackson, MS 39202

Table 1: SENSORS FOR ADAPTIVE RATE CARDIAC PACING

Standard Pacing Lead	Special Pacing Lead
Activity (vibration, accelerometer, position/motion sensor)	RV dP/dt
QT interval	RV stroke Volume
Respiratory rate	RV pre-ejection period
Minute ventilation	RV dz/dt
Ventricular depolarization gradient	Central venous pH
	Central venous O_2 saturation
	P wave averaging

RV = right ventricle; dP/dt = rate of change of pressure; dz/dt = rate of change of volume

REFERENCES

1. Hayes DL, Osborn MJ. Pacing: Antibradycardia Devices, in Cardiology: Fundamentals and Practice, ed 2, Giuliani ER, Fuster V, Gersh BJ, et al (eds). St. Louis, Mosby-Yearbook, 1991, p 1043.
2. Rosenqvist M, Brandt J, Schuller H. Long-term pacing in sinus node disease: effects of stimulation mode on cardiovascular morbidity and mortality. *Am Heart J* 1988;116:16-22.
3. Alpert MA, Curtis JJ. Sanfelippo JF, et al. Comparative survival after permanent ventricular and dual chamber pacing for patients with chronic high degree atrioventricular block with and without preexistent congestive heart failure. *J Am Coll Cardiol* 1986;7:925-932.
4. Alpert MA, Curtis JJ, Sanfelippo JF, et al. Comparative survival following permanent ventricular and dual-chamber pacing for patients with chronic symptomatic sinus node dysfunction with and without congestive heart failure. *Am Heart J* 1987;113:958-965.
5. Langenfeld H, Grimm W, Maisch B, et al. Atrial fibrillation and embolic complications in paced patients. *PACE* 1988; 11:1667-1672.
6. Parsonnet V, Hesselson AB, Harari DC. Long-term functional integrity of atrial leads.

PACE 1991;14:517-21.
7. Rosenqvist M, Obel IWP. Atrial pacing and the risk for AV block: is there a time for change in attitude? *PACE* 1989;12:97-101.
8. Carisma MBO, Mamalo JM, Chua WT. Atrioventricular conduction in sick sinus syndrome. *PACE* 1988;11:1636-1640.
9. Rosen KM, Loeb HS, Sinno MZ, et al. Cardiac conduction in patients with symptomatic sinus node disease. *Circulation* 1971; 43:836-844.
10. Alt E, Heinz M, Theres H, et al. Function and selection of sensors for optimum rate modulated pacing, in New Perspectives in Cardiac Pacing. 2, Barold SS, Mugica J (eds). Mount Kisco, Futura, 1991, pp 163-202.
11. Benditt DG, Mianulli M, Fetter J, et al. Single-chamber cardiac pacing with activity-initiated chronotropic response; evaluation by cardiopulmonary exercise testing. *Circulation* 1987; 75:184-191.
12. Smedgård P, Kristnesson BE, Kruse I, et al. Rate-responsive pacing by means of activity sensing versus single rate ventricular pacing: a double-blind cross-over study. *PACE* 1987; 10:902-915.

Dr. Fyke practices cardiology with Cardiovascular Associates, P.A. in Jackson and currently serves as Chief of Cardiology at the Mississippi Baptist Medical Center. He is on the National Advisory Panel for the North American Society of Pacing and Electrophysiology and on the examination committee for NASPExAM.

The Journal of the Mississippi State Medical Association welcomes material for review and publication.

Information For Authors **is listed on pages 416-417 of this issue.**

For additional information or questions about submitting articles please write or call,
The Journal Of The Mississippi State Medical Association.
PO Box 5229, Jackson, MS 39296-5229
(601) 354-5433 • 1-800-898-0251

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE

The MSMA provides a toll free WATS for any member to call to inquire about programs and policies of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

LIAISON SERVICES

MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE

MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA

BUSINESS AND PERSONAL INSURANCE

The MS Physicians Insurance Company (MPIC) through its managing general agency, Evans and Giordano, offers a wide range of low cost business and personal insurance for members of the association. MPIC has a Board of Directors appointed by MSMA composed entirely of practicing physicians who with the advise and assistance of Evans and Giordano seek to identify the special insurance needs of physicians. For further information call Evans and Giordano.

PRACTICE MANAGEMENT

Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE

Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call Robert Kidd at MSMA.

FINANCIAL/RETIREMENT PLANNING

MSMA members by virtue of their membership in the AMA are eligible to participate in AMA Investment Advisors, Inc. This wholly owned investment subsidiary of the AMA offers a wide range of investment opportunities tailored specifically for physicians. For further information call AMA Advisers.

MEDICAL MALPRACTICE INSURANCE

The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. More than 1500 Mississippi physicians are currently insured by MACM and extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-534-5433 or 800-898-0251 (In-State-WATS).

AMA Advisers - 200 N. LaSalle Street, #535, Chicago, IL 60601, 800-525-0864.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - (Evans and Giordano, Managing General Agency) - P.O. Box 12978, Jackson, MS 39236-2978, 601-957-5100 or 800-748-9713 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-200 or 800-325-4712 (In -State-WATS).

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Services

When you need information on a specific subject or association service, the following MSMA staff person(s) are available to assist you.

Address Changes • Barbara Shelton

Advertising • Ginger Cocke

Annual Meetings:
- **Delegates** • Barbara Shelton
- **Scientific Exhibits** • Ginger Cocke
- **Technical Exhibits** • Kay Gatewood
- **Meeting Schedule** • Ginger Cocke

Bills and Invoices • Robert Kidd

Board of Trustees & Officers • Charles Mathews

CommuniCare/Complaints from the Public/ Office /Brochures • Lora Lane

Continuing Medical Educations (CME) • Lora Lane

Component Medical Societies • Barbara Shelton

CPT/ICD-9 Inquiries • Debra Collins

Directories (MSMA and Auxiliary member listings) • Barbara Shelton

Dues (MSMA & Auxiliary) • Barbara Shelton

Government:
- **State** • Clare Hester
- **National** • Bill Roberts

Health Care Statistics and Data • Bill Roberts

Insurance Form Orders • Lucy Spence

Journal MSMA • Ginger Cocke

Legislative Activities • Clare Hester

Licensure • Bill Roberts

Mail Lists & Labels • Lucy Spence

Media (Radio, TV, Press) • Ginger Cocke

Medical Ethics • Bill Roberts

Medical Student Membership • Barbara Shelton

Medicare/Medicaid • Jackye Wiebelt

Member Benefits • Bill Roberts

MMPAC/AMPAC • Clare Hester

Physician Referrals • Lora Lane

Practice Management Workshops • Debra Collins

Public Information • Ginger Cocke

Resident Physician Membership • Barbara Shelton

Scientific Assembly • Ginger Cocke

Young Physician Section • Bill Roberts

MSMA Office

735 Riverside Drive
Jackson, MS 39202
(601) 354-5433

P. O. Box 5229
Jackson, MS 39296-5229
MS WATS (800) 898-0251

FAX: (601) 352-4834



The President's Page

WILLIAM C. GATES, MD

Sovereign Immunity
(*res ipsa loquitur*)

Sovereign immunity had its origin in medieval England when the courts were controlled by the king and the doctrine protected him from suit by his own court.

The idea of immunity for political subdivisions made its way into our judicial case law as common law, but in the last two decades judicial support of this concept has been eroding.

In Mississippi, the Legislature has annually postponed the effective date of statutory sovereign immunity and, as in the past, has continued to utilize sovereign immunity case law as common law.

The recent ruling of the Mississippi Supreme Court, by quirks in the temporal relationships, created for almost a year a period during which the State and its agencies, counties and municipalities faced potential unlimited liability. This sent the State government hurriedly into special session in order to pass get-by legislation to cover the gap.

The Mississippi Legislature will again attempt to address the issue early next year and we must hope that the incongruity of our current civil justice system will also be addressed. This presupposes that there is the will, the leadership and the vision to accomplish something that is so necessary for the common good.

The Mississippi Supreme Court's emasculation of the Sovereign Immunity law, followed by the legislature's scrambling to enact some substitute protection, is only the latest episode in a series of disasters which the American civil justice system has thrown at the very people whose interest it ostensibly protects. In actuality, the only persons the system really protects are the plaintiff attorneys who continue to reap obscene contingency fee profits from jury awards — all under the guise of ensuring that one is "responsible for the consequences of their actions".

(Continued on page 396)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 11
NOVEMBER 1992

Media Managed Politics And Medical Care

We have just suffered through weeks and months of the media barrage that we call politics. I'm not certain if the best man won ..... if there was a BEST man, or whether there was a real winner, or not. One thing is certain and that is that we need a drastic change in our electoral process.

Ever since Watergate, when the news-media first found that it was powerful enough to bring down a president, it has muscled its way into managing public opinion so thoroughly that they convince us of what we are to think and who or whatever issue we should support or oppose. No longer does the news-media just report happenings. It investigates and makes things happen. It is not mind over matter anymore, it is the media's control over the American public's mind.

One thing that we in medicine can see from this election is that there will be a drastic change in health care policy. Each of the party platforms had health care as one of the major issues that will be changed. I'm not certain what the news-media will have us think yet, but you can be assured that they will have their own pet policy that they will push on the unsuspecting populace. With the owner's of many of the prominent news-media being staunch liberals, we can almost guarantee that there will be a concerted effort to raise taxes and cut physicians' incomes in order to provide money for all the give-away programs that are down on their agenda.

Let us all work together to influence the new members in office in a positive manner. Let us show them that our present system is still the best for all and only needs shoring up by having wider coverage of the underprivileged and an appreciation of the fact that many people don't have health care by choice.

We can only hope that the media, in all its might, will once and for all get off our necks and let us do the job that we know how to do best.... that of providing the highest quality medical care for the most people.

Thank God I am a physician.

Joseph E. Johnston, MD
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

President's Page

(Continued from page 394)

Supreme Court Justice "Chuck" McRae would have us believe that if it were not for our system of civil "tort" law, we would be running helter-skelter over the rights of each other and that granting civil protection to municipalities would lead to a world in which garbage trucks motor about the countryside mowing down a helpless citizenry simply because the drivers cannot be sued for damages.

As a society, we have so long bought the tort argument and the gonzo social philosophy it fosters — that every wrong must be righted and every person who commits a wrong must be made to pay for it — that we are now teetering on the edge of financial chaos from paying increased prices for goods and services and higher taxes to bankroll a self-indulgent, bloated liability system.

It has been reliably stated that anywhere from 15-20% of our total health care expenditures are attributable to our ruinous liability system. In 1989 alone, total liability costs related to physician services in the United States were $20.7 billion. According to the President's Council on Competitiveness, individuals, businesses and government spend more than $80 billion a year on direct litigation costs and higher insurance premiums, and a total of up to $300 billion indirectly, including the cost of efforts to avoid liability — and we wonder **why** the **costs** of health care are so **high.**

Who benefits from the billions of dollars flowing out of jury boxes all over the country? According to a recent study by the Rand Corporation, only 45% of the annual jury awards or settlements from lawsuits in any given year ultimately reach the hands of the aggrieved plaintiffs. The remaining 55% goes to the plaintiff's lawyers and to pay the other myriad transaction costs of our judicial system. The trial lawyers' hold on the neck and wallet of our society needs to be loosened.

If the Mississippi Legislature wants to avoid financial disaster for public institutions and agencies, if the Legislature wants to lower health care costs and improve access to healthcare for its citizens and if the Legislature desires to promote industrial development, increase job opportunities and improve the tax base in Mississippi, then the legislature needs to end its duplicity in maintaining a legal system which subjects the private sector to burdens which the public sector ostensibly "can't afford".

Now that government agencies are about to be exposed to the same harassment and ruinous expense which have come to be an everyday part of the litigious environment of everyone else maybe we can bring about some meaningful change in the tort law which will be beneficial to everyone. All, that is, except for the trial lawyers who will lose in tort reform because they have been the principle beneficiaries and the principle instigators of the resource-consuming corruption of the tort system.

It is past time that the Mississippi Legislature, and all citizens for that matter, be awakened to the fact that we are "being had" by a tort system and trial bar that has run amuck and that changes in our civil justice system are long overdue. Let us pray there is enough leadership and statesmanship to see that the job is done. After all, "the thing" truly does, "speak for itself".

I hope my note finds you and yours doing well.....

Best regards,
Bill

Letters

To the MSMA:

The obituaries which appeared in the Jackson *Clarion Ledger* and the August *Journal of the MSMA* simply stated the facts and accomplishments of Dr. Tom Blake's life. What was left unsaid was the tremendous influence his life and his works had on his fellow physicians and the people of Mississippi.

I came back to Mississippi in November 1945 after five years service in W.W. II and began a general practice in Laurel. There were no Board Certified Orthopedists, Surgeons, Internists or any other recognized specialty in the county. The doctors in Laurel did virtually everything and I quickly learned to refer my most difficult orthopedic cases to Dr. Tom Blake. He was always receptive and in addition always available to give advice on how to manipulate arms or legs to reduce certain fractures. I can remember many times calling him for advice and most of the time he would tell me what to do and if I could not achieve the desired results I would refer them to him. Many were to the Crippled Children's Service which he helped found. Many others were adults who were not able to pay. He never refused to take anyone and would give everyone his expert attention.

One of the recipients of Dr. Tom's skill is our present Circuit Judge, B. J. Landrum who, as a boy was run over by an automobile when he was riding his bicycle. He spent almost two years in the Mississippi Baptist Hospital in the Mississippi Crippled Children's Service. To this day he reveres Dr. Blake and gives all credit for his complete recovery to him.

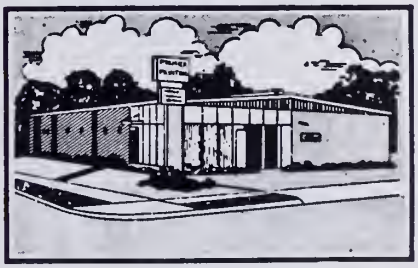
In Laurel from 1946 to 1952 there were two physicians who were acknowledged as "good bonesetters". They were the late Dr. Eugene A. Bush and the late Dr. H. L. (Jack) Boone who were superior at the manipulation but they often consulted Dr. Blake when they did not get the desired result. It wasn't until 1952 when the Jones County Community Hospital was opened the Laurel was able to attract an Orthopedic Surgeon, the late Dr. Jimmy Bass. Now we have four excellent Orthopedic Surgeons, one of whom is Dr. Thomas Blake, Jr., the elder son of Dr. Tom.

I will always cherish the memory and friendship of Dr. Tom along with the many other Mississippians whose lives he counseled and enriched. To paraphrase my good friend Dr. Joe Johnston ... Thank God for physicians like Dr. Thomas Blake.

Rod Jenkins, MD
Laurel, MS

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

American Medical Association

Physicians dedicated to the health of America

For Your Benefit

AMA Successfully Obtains 90 Day CLIA Grace Period

The American Medical Association successfully persuaded HCFA to grant a 90-day grace period for the Clinical Laboratory Improvement Act of 1988 during which Medicare claims will NOT be denied if your CLIA registration number is omitted. Health and Human Services Secretary Louis Sullivan, MD, also upheld the AMA's objections to unannounced surveys of physicians' office labs saying that those investigations will take place only if a problem is suspected or a complaint is filed. Routine surveys during the first 2-year cycle will be educational.

AMA Is Your Advocate in Washington

Physician Advertising. The AMA General Counsel's Office is negotiating with the Federal Trade Commission to develop guidelines for physician advertising. The FTC's Bureau of Competition has approved all the AMA's proposed guidelines and is discussing the last one which deals with claims about the physician's board certification credentials.

Safety Regulations. The AMA urged the Senate Labor Committee to exempt physicians from proposed federal legislation, S. 1622, requiring employers to develop safety and health programs for employees. The AMA pointed out that these regulations duplicate those existing Occupational Safety and Health Administration requirements that apply to physicians.

HIV Disease. In a letter to the Social Security Subcommittee of the House Ways and Means Committee, the AMA supported legislation that would make it easier for people with HIV disease to receive Social Security disability benefits.

Practice Parameters. The AMA addressed the Agency for Health Care Policy and Research outlining the AMA's views on translating clinical practice guidelines into medical review criteria, standards of quality and performance measures.

"Current Opinions"

of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON PRACTICE MATTERS

Informing Families Of Patient's Death

Disclosing the death of a patient to the patient's family is a duty which goes to the very heart of the physician-patient relationship and should not be readily delegated to others by the attending physician. The emotional needs of the family and the integrity of the physician-patient relationship must at all times be given foremost consideration.

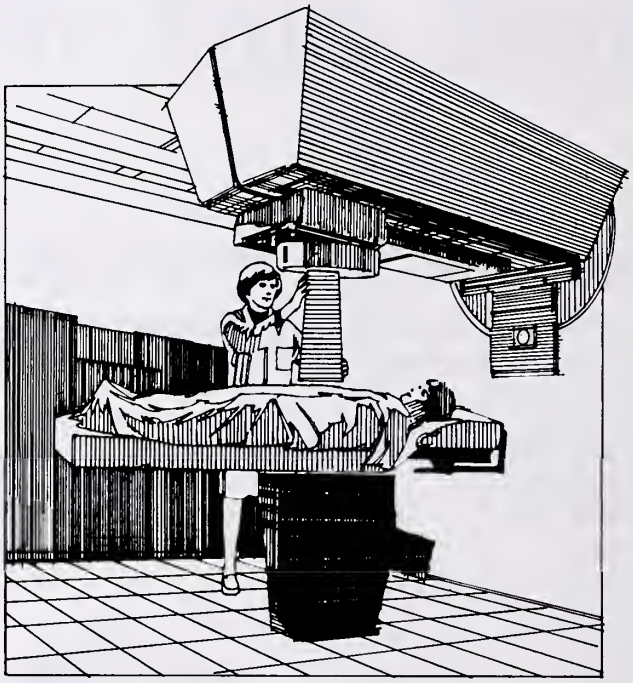
Physicians in residency training may be asked to participate in the communication of information about a patient's death, if that request is commensurate with the physician's prior training or experience and previous close personal relationship with the family.

It would not be appropriate for the attending physician to request that a medical student notify family members of a patient's death. Medical students should be trained in issues of death and dying, and should be encouraged to accompany attending physicians when news of patient's death is conveyed to the family members. ❑



Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Medical Organization

Pontotoc's Dr. John Patterson Named Family Physician of the Year

Dr. John M. Patterson, a Pontotoc Physician for 37 years, recently was named the Family Physician of the Year by the Mississippi Academy of Family Physicians.

The highest honor bestowed on a family physician, the award is given in recognition and appreciation for outstanding leadership and services to family medicine in Mississippi.

Dr. Patterson served three years in the U. S. Navy and Naval Air Force. He received a bachelor of science degree from the University of Mississippi in 1953 and his medical degree from Jefferson Medical School in Philadelphia, Pennsylvania in 1954. He completed his family medicine residency at Baptist Memorial Hospital in Memphis.

He entered private practice in Pontotoc in July 1955 and has served several terms as Chief of Staff at Pontotoc Hospital. Dr. patterson also serves as a member of the Courtesy Staff of North Mississippi Medical Center in Tupelo. Both NMMC and Pontotoc Hospital are operated by North Mississippi Health Services.

"I think everyone who knows Dr. Patterson would agree that his caring and compassionate personality have endeared him to countless patients over the years," said Fred B. Hood, administrator of Pontotoc Hospital. "He truly represents the consummate gentleman physician, and we are pleased that he is being recognized statewide for all he means to health care in our local area and across Mississippi."

Dr. Patterson presently serves as District Director of the Mississippi Academy of Family Physicians (MAFP) and president of the Family Health Foundation of Mississippi, the philanthropic arm of MAFP. Dr. Patterson also serves as member of the Board of Directors for the University of Mississippi Medical Center in Jackson.

He is a member of many medical associations and societies, including the American Academy of Family Physicians and the American Medical Association, in addition to regional, state, and local organizations.

Aside from his responsibilities to his patients, the hospital, and his profession, Dr. Patterson is extensively involved in community activities in Pontotoc and northeast Mississippi. A member of the Pontotoc Lions Club, he attends the Methodist church and serves on its Board of Trustees. He is also a trustee of Traceway Manor in Tupelo, a senior citizen facility.□

Simmons Arboretum Embarks On Five-year Plan To Promote Nature

It's the first step in a five-year plan that has nature enthusiasts excited. In August a sign dedication was held at the Simmons Arboretum off St. Augustine Drive in Madison.

Bill Knapp, chairman of the arboretum committee said that people's involvement is making the project a reality. Knapp took on the project in January and began working to put into motion the building of the arboretum.

The project began several years ago when Dr. and Mrs. Walter H. Simmons donated ten acres of land located near the Natchez Trace and Ross Barnett Reservoir to the city of Madison. The park, according to Simmons' request, will have at least one specimen of every tree and bush indigenous to Mississippi. Markers will identify the plants and briefly describe their characteristics and growing patterns. A walking path and jogging trail will wind through the park.

Knapp said getting residents to take part in the project has netted over $100,000 in in-kind work for the nature area.

A fund-raising campaign is

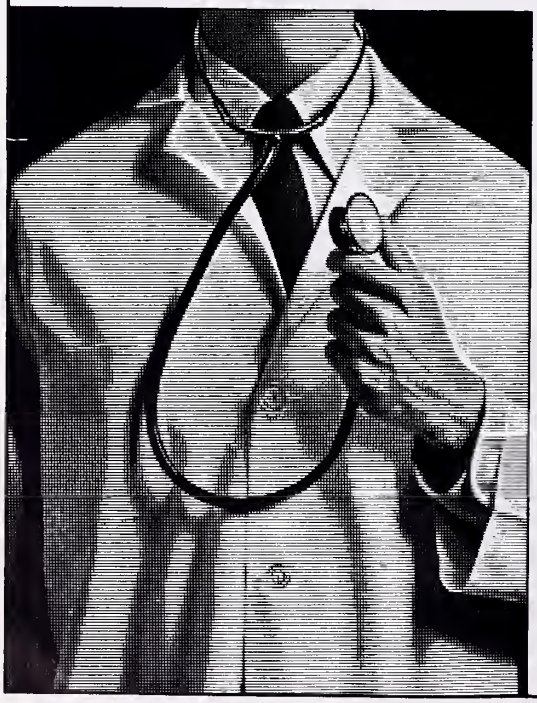
currently underway, where the committee is offering engraved paving bricks at a cost of $30 for individuals and $50 for business. Knapp said over $600 had been raised on brick sales thus far.

Members of the arboretum committee have already cleared a temporary walking trail and the parking area entrances have been put in by the city. Other members have begun identifying species of plants and wildlife within the area.

When he donated the land, Dr. Simmons said, "I've always loved being out in nature and just wanted to give part of my land to preserve it intact. This should be a learning experience as well as something beautiful and serene".

Dr. Simmons has served the Mississippi State Medical Association as Secretary-Treasurer and Speaker of the House of Delegates. ❑

FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment–Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

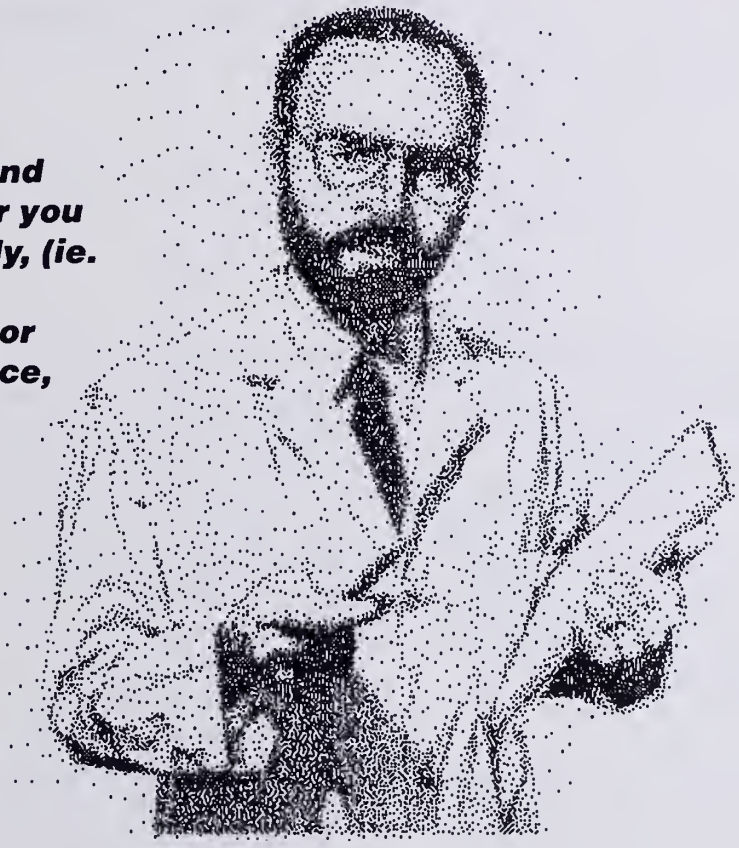
It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect .

ARMY HEALTH CARE TEAM

(901) 725-5851 or 5852 / (504) 522-1871 or 1872

ARMY MEDICINE. BE ALL YOU CAN BE.

What can Employer Plus do for me personally, as a doctor?



For every dollar you spend on benefits for you and your family, (ie. health dental, disability, life or vision insurance, as well as dependent care or medical costs) we can save you at least 38 cents in Federal and State taxes on each dollar you are currently spending.

The choice is yours, do you continue to pay your money to the government or do you put more money in your pocket? Contact Employer Plus today, we'll discuss all the details on a personal and confidential basis. Call us

Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

© 1992 Employer Plus. All rights reserved.

From the University of Mississippi Medical Center

Dr. Francis Morrison Lectures In Buenos Aires, Argentina

Dr. Francis Morrison, a UMC professor of medicine, will present two lectures at a seminar sponsored by the Group Latino American Hemapheresis in Buenos Aires, Argentina this month.

The recipient of a transfusing medicine academic award from the National Heart, Lung and Blood Institute (NHLBI), Dr. Morrison will deliver the seminar's opening lecture "Therapeutic Apheresis: A Critical Review of Clinical Applications". He will discuss new technologies and perspectives in hemaperesis during a second session.

The lectures are two of many Dr. Morrison has been invited to present since receiving the NHLBI award in 1989. In August, he spoke to the Scientific Research Center for Hematology of the Russian Academy of Medical Science in Moscow where he discussed indications and problems in hemapheresis. Dr. Morrison also addressed the World Apheresis Association Meeting in Sapporo, Japan in June. Last month, he met with the World Health Organization's director of Global Blood Safety Initiatives in Geneva, Switzerland under the auspices of the blood program director of the Federation of Red Cross and Red Crescent Societies.

Since joining the faculty in 1969, Dr. Morrison helped establish a statewide blood products network for Mississippi hospitals, first as founder of the Jackson Community Blood Bank, Inc., in 1973, and in 1975 as founder, executive director and long-time board member of the Mississippi Regional Blood Center, (now Mississippi Blood Services, Inc.)

Dr. Morrison chaired the American Blood Commission Task Force on Regionalization in 1978. In 1991, he served as president of the American Society for Apheresis and later of the World Society. He also is a member of the House of Delegates of the Mississippi State Medical Association.

Dr. Morrison is vice chairman of the Clinical Cancer Committee and an organizing member and consultant to the Transfusion Committee. He served on the Faculty Senate from 1972-1973, was president of the UMC Clinical Associates from 1975-1978. From 1986-87, he was Chief of Staff and Chairman of the Executive Committee for the University Hospital.

A graduate of Mississippi State University and the Medical Center, he completed residency training at the Hospital of the University of Pennsylvania and a fellowship in the Blood Research Laboratory of Tufts New England Medical Center in Boston, Massachusetts, where he also was a member of the faculty.

Dr. Morrison has authored numerous scientific publications, including eight book chapters and one book on transfusion therapy.

The NHLBI award is geared to promoting advancements in transfusion medicine at UMC and throughout the state. It provides about $150,000 annually for five years.

"Part of it is designed to influence the medical, dental and nursing curricula," Dr. Morrison said.

Funds from the award supported transfusion research projects for eight UMC students this summer. ❑

Harvey Mason Attends ACS Clinical Congress

Harvey Mason, a senior medical student at the University of Mississippi Medical Center, will attend the 78th Annual Clinical Congress of the American College of Surgeons October 11-16 in New Orleans. He is one of 40 senior medical students nationally to attend the congress. Medical students are invited to the congress on the basis of academic performance, faculty recommendation and specialty interest.

A native of New Albany, Mason is a four-tine recipient of the Schillig Scholarship, a full-tuition scholarship established in memory of concert singer Ottilie Schillig. He will attend post graduate courses, discuss surgical specialties and meet with surgeons during the clinical meeting.

The American College of Surgeons was established in 1913 by surgeons from the U.S. and Canada. ❑

You'll love working with our locum tenens physicians and allied health care professionals.

WE GUARANTEE IT.

CompHealth has thoroughly credentialed physicians and allied health care providers from more than 40 fields of specialization available to provide locum tenens, or temporary, staffing assistance when and where you need it.

Plus, we have the standards and experience to guarantee your satisfaction each time we place a member of our medical staff in your practice or facility. It's the closest thing you'll find to a risk-free way to cover for absent staff members, "try out" a potential new recruit, or take care of your patients while you search for a new full-time associate.

Call us today to arrange for quality locum tenens coverage, or to discuss your permanent recruiting needs.

CompHealth

COMPREHENSIVE HEALTH CARE STAFFING

1-800-453-3030

Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

The Delta Region AIDS Education and Training Center grant is one of 17 federally funded for specialized comprehensive HIV/AIDS Education and Training in Arkansas, Louisiana, and Mississippi. Educational offerings are available in six disciplines - medicine, nursing, dentistry, infection control, mental health, and social work. Physicians, nurses, and health-related professionals are available to visit your area and provide educational services. Please include us in your next meeting. Additional information may be obtained by calling the Division of Infectious Diseases, University of Mississippi Medical Center.

Jan M. Evers, RN, MN, Resource Center Director
(601) 984-5560
(601) 984-5565 FAX
2500 North State Street, Jackson, MS 39216-4505



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

New Members

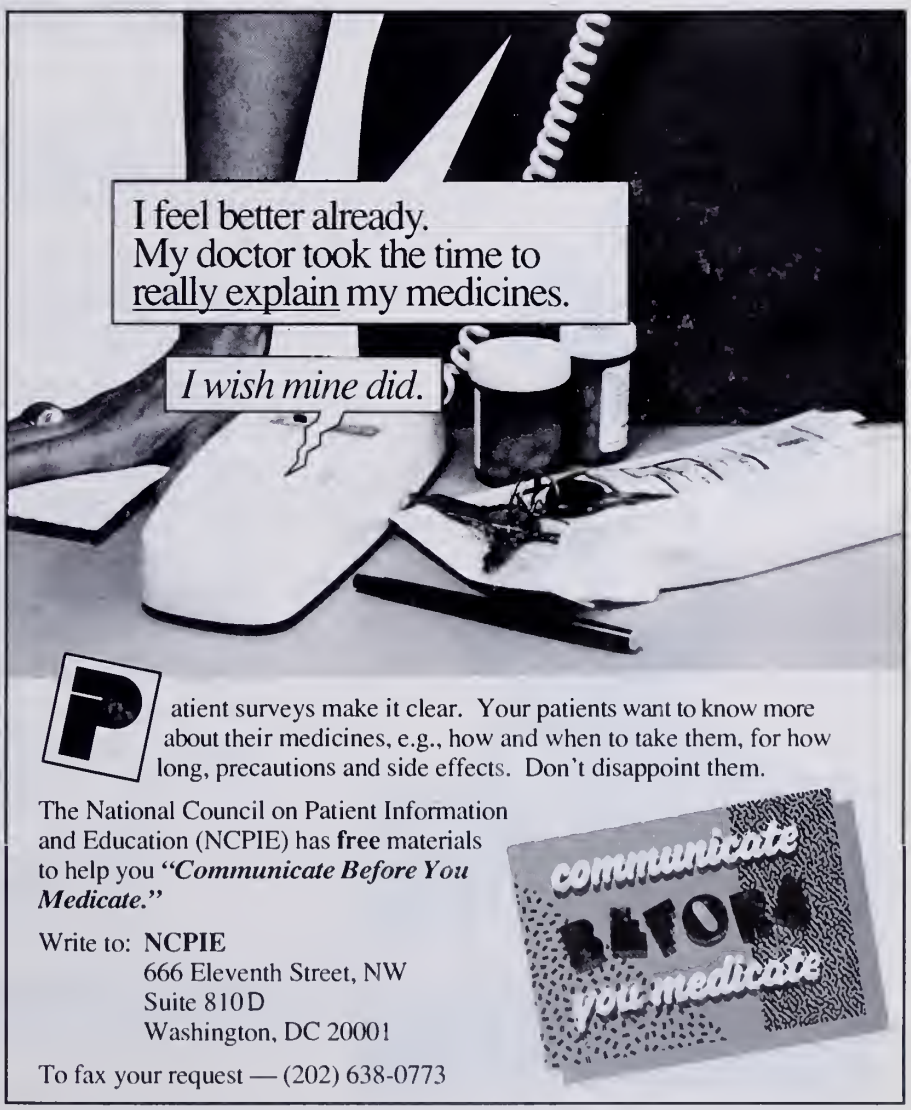
Barnes, Gary T., Jackson. Born Louisville, MS, July 1, 1958; MD, Louisiana State University School of Medicine, New Orleans, LA, 1984; interned one year, Same; emergency medicine residency, University of Florida University Hospital, Gainesville, FL, 1985-87; elected by Central Medical Society.

Brandon, Steven C., Starkville. Born Starkville, MS, October 23, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; family practice residency, Roanoke Memorial Hospital, Roanoke, VA 1988-91; elected by Northeast Mississippi Medical Society.

Brown, Brett O., Columbus. Born May 8, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; internal medicine, Same, 1989-92; elected by Prairie Medical Society.

Cole, Craig A., Jackson. Born Jackson, MS, December 24, 1955; MD, University of Virginia School of Medicine, Charlottesville, VA, 1982; interned and one year surgery residency, Tulane Medical School Hospital, New Orleans, LA, 1982-84; surgery residency St. Agnes Hospital, Baltimore, MD, 1984-87; elected by Central Medical Society.

Daggett, Robert B., Meridian. Born Houston, TX, December 23, 1948; MD, University of Illinois College of Medicine, Chicago, IL, 1974; interned one year, US Naval Hospital, Portsmouth, VA; internal medicine residency, US Naval Hospital, San Diego, CA, 1975-77 and pediatric residency, same, 1975-78; rheumatology fellowship, University California, San Diego, CA, 1988-90; elected by East Mississippi Medical Society.



Patient surveys make it clear. Your patients want to know more about their medicines, e.g., how and when to take them, for how long, precautions and side effects. Don't disappoint them.

The National Council on Patient Information and Education (NCPIE) has **free** materials to help you ***"Communicate Before You Medicate."***

Write to: **NCPIE**
666 Eleventh Street, NW
Suite 810D
Washington, DC 20001

To fax your request — (202) 638-0773

Doyle, Donald E., Pascagoula. Born Greenville, MS, April 10, 1940; MD, New York Medical College, New York City, NY, 1967; one year internship Cedars-Sinai Medical Center, Los Angeles, CA; surgery residency, same, 1968 and 1970-71; residency in dermatology, Wadsworth VA Hospital, Los Angeles, CA, 7/71-12/71; otolaryngology and head and neck surgery residency, White Memorial Hospital, Los Angeles, CA, 1972-75; elected by Singing River Medical Society.

Goodman, Barbara B., New Albany. Born Eupora, MS, July 30, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned one year and family medicine residency, same, 1989-92; elected by Northeast Mississippi Medical Society.

Holland, John G., Hattiesburg. Born Jacksonville, FL, April 25, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned and ob-gyn residency, same, 1988-92; elected by South Mississippi Medical Society.

Okoye, Samuel C., Bolton. Born Nigeria, February 19, 1960; MD, University of Missouri School of Medicine, Columbia, MO, 1988; interned and family medicine residency, Southside Hospital, Bayshore, NY, 1989-92; elected by Central Medical Society.

Ray, Linda I., Jackson. Born Jackson, MS, October 1, 1956; MD, University of Mississippi School of Medicine, Jackson, MS, 1982; pediatric residency, University Medical Center, Jackson, MS, 1982-85; ambulatory medicine fellowship,



FLIGHT SURGEONS WANTED.

Discover the thrill of flying, the end of paperwork and the enjoyment of a general practice as an Air Force flight surgeon. Take flight with today's Air Force and discover quality benefits, 30 days of vacation with pay each year and the support of a dedicated staff of professionals. Enjoy a true general practice on the ground, with the kind of stimulating challenge that will get your medical skills airborne. Talk to an Air Force medical program manager about becoming an Air Force flight surgeon. Call

USAF HEALTH PROFESSIONS
TOLL FREE 1-800-423-USAF

AIR FORCE

same, 1985-86; rheumatology fellowship, University of Texas at Southwestern, Dallas, TX, 1990-92; elected by Central Medical Society.

Senter, Bruce S., Jackson. Born New Orleans, LA, February 9, 1960; MD, Louisiana State University School of Medicine, New Orleans, LA, 1986; interned and ortho surgery residency, University Medical Center, Jackson, MS, 1986-91; spinal fellowship, Tulane Medical School of Medicine, New Orleans, LA, 1991-92; elected by Central Medical Society.

Yanez, Dimitri A., Bay St. Louis. Born Mexico City, Mexico, April 2, 1955; MD, University of Iowa College of Medicine, Iowa City, IA, 1983; interned and ob-gyn residency, LSU Division of Charity Hospital, New Orleans, LA, 1983-87; elected by Coast Counties Medical Society. ❑

The Hospital Medical Staff Section Twentieth Assembly Meeting December 3 - 7, 1992 Opryland Hotel Nashville, Tennessee

Medical Staffs from the country are encouraged to elect a medical staff representative to participate in the AMA-HMSS Assembly Meeting December 3 - 7, 1992, Opryland Hotel, Nashville, Tennessee.

The HMSS Assembly provides medical staffs with a unique opportunity to discuss and participate in the policymaking process of the AMA.
In addition to the Assembly Meeting, an educational program on:

Part 1: A Futurist's Picture of Health Care 2000
Part 2: Physician/Hospital Organizational Models for the future

If you are unable to participate in the Nashville Meeting,
we encourage you to call us with the name of your HMSS Representative.

For future information about the AMA-HMSS,
please call 312 464-4754 or 464-4761.



Hospital Medical Staff Section

American Medical Association

Physicians dedicated to the health of America



To Relieve the Symptoms of Stress From Travel



Call Avanti Travel, Inc. For All Of Your Business and Leisure Trips for Stress-Free Travel!

Avanti Travel is staffed with highly professional consultants who have extensive backgrounds in the travel industry. Avanti's specialists offer you the personal service and attention to details that you expect and deserve.

Avanti Travel offers you these amenities:

- 24- hour reservation service
- Toll free nationwide numbers and toll free numbers from 39 foreign countries
- Guaranteed lowest applicable airfares
- Last seat availability on major airlines
- Savings up to 45% on selected hotels in the United States and throughout the world
- All day ticket delivery and airport "will-call" box
- Lost luggage tags

The next time you make travel arrangements, Call Avanti Travel, Inc. for stress-free travel.



Three Lakeland Circle • Jackson, Mississippi 39216 • 981-9111
Call Toll-Free Nationwide 1-800-748-8744

Personals

Paul M. Allen, a gynecologist and obstetrician, practicing in Pascagoula, attended the 13th Annual Meeting of the American Urogynecologic Society in Cambridge, Massachusetts.

Kirk J. Banquer has associated with the Surgery Clinic of Hattiesburg, P.A. for the practice of general, thoracic, and vascular surgery, and GI endoscopy, Methodist Medical Park, 105 Asbury Circle, Hattiesburg.

Stephen Beam, medical director of Work Well, has received certification in occupational medicine by the American College of Occupational and Environmental Medicine (ACOEM).

Stephen C. Brandon announces his association in the practice of Family Medicine with special interests in pediatrics, newborn care, office gynecology, and minor office surgery with **Leonard H. Brandon**, and **Barbara A. Fleetwood** at The Family Clinic, 501 Hospital Road, Starkville.

Harry L. Butler, a hematologist and oncologist practicing in Hattiesburg, recently achieved certification as a diplomat in the subspecialty of medical oncology.

John T. Chmelicek has associated with Purvis Family Practice Clinic in the practice of family medicine with **E.G. Duck** and **Michael R. O'Neal**, 102 Shelby Speights Drive, Purvis.

Robert C. Clingan of Vicksburg has been named Medical Director of Blue Cross and Blue Shield of Mississippi, with responsibilities including medical policy and medical review.

Craig A. Cole announces the opening of his office for the practice of general surgery, 1815 Hospital Drive, Jackson.

John Joseph Durfey has associated with Jackson Anesthesia Associates, P.A. for the practice of anesthesiology, 508 Medical Arts Building, Jackson.

Eric M. Dyess has associated with Meridian Medical Associates, P.A., in the practice of endocrinology, 2024 15th Street, Meridian.

George Furr of Clarksdale was featured in a full page article recently in *The Clarksdale Press Register* for his continuous campaign to educate public officials and citizens about health hazards.

Alice Gorton has joined the staff of Madden Medical Clinic, 1071 E. Franklin Street, Carthage, MS.

(Continued on page 413)

Do your Retirement Plan Investments need a *Shot in the Arm*?...

Consider Medley & Company.
We access top-notch money managers through no-load mutual funds - using a proven asset allocation model - so that you can have a *healthy* retirement plan.

Call for a free brochure.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 1/800 / 844-4123

Several Reasons Why

MPIC's
"Worker's Compensation Program"

Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings
✔ 2. Established by Your Association	Up To
✔ 3. Savings over what you currently are paying	~~15%~~
✔ 4. Responsive to your needs	30 %
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 957-5100
(800) 748-9713

Sponsored by the Mississippi State Medical Association

Physicians' Recognition Award

Three MSMA members were named recipients of the AMA Physicians' Recognition Award in September 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by medical society.

Central Medical Society

Mary B. Wheatley, MD

East Mississippi Medical Society

Austin P. Boggan, MD
Walter R. Holladay, MD

Personals/continued

Joseph E. Johnston of Mt. Olive has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Michael R. Lewis has associated with **Paul E. Mullen** and **Eva Magiros**, Coast Cardiovascular Consultants, for the practice of cardiology.

Christopher V. Matthews has been named chief of the medical staff of the Pearl River Medical Complex in Poplarville.

Clyde Ray McLaurin, of the Family Health Center, 350 Highway 43S Canton, completed the American Board of Family Practice Recertification Examination and has been recertified as a diplomate.

Carroll M. McLeod has associated with the Jackson Anesthesia Associates, P.A., for the practice of anesthesiology, 508 Medical Arts Building, Jackson.

Monica L. Northington of Jackson was recently elected to fellowship in the American Academy of Pediatrics.

J. Steve Purdon, Tim Wright, and **Nelson Little** announce the opening of their Batesville Clinic of Cardiology Consultants of Oxford at South Panola Community Hospital. ❑

Send Items for the
Personals Column
to the Editor,
Journal MSMA
PO Box 5229,
Jackson, MS 39296-5229

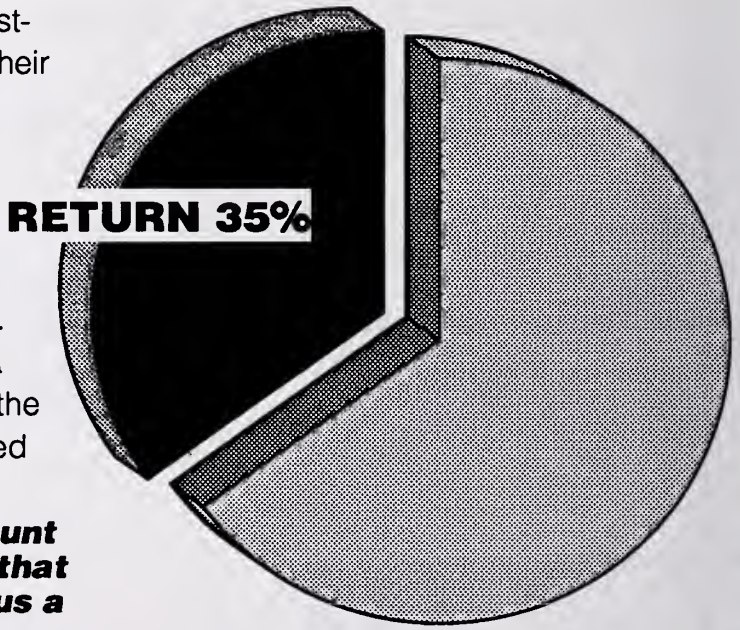
In 1991 our retirement funds earned an average 35% return on investments.*

Employer Plus offers our clients a family of select mutual funds, from one of the nation's leading investment banking firms, to use for their retirement plan investment.

Recent figures for the year 1991, show the ten mutual funds that we most recommended for our clients, averaged a **35%** overall return. One of the ten produced over a **56%** return. the highest, while the lowest return of the ten produced just under a **20%** return.*

If your retirement account is not producing a return that you are happy with, give us a call.

We can help.



Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

**Past performance is no guarantee of future returns.*

© 1992 Employer Plus. All rights reserved.

You're a Professional.

You need Professional Health Insurance Coverage.

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39296-5509

Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

Key Words should follow the abstract and be identified as such. Provide three to five key words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

References must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

Journals

[1] **Author(s).** Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] **Title of article.** Capitalize only the first letter of the first word. [3] **Name of Journal** followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] **Year of publication;** [5] **Volume number:** Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] **Inclusive page numbers.** Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol* 1979;71:680-692.

Books

[1] **Author(s).** Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] **Title,** Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less that four letters. [3] **Edition number,** [4] **Editor's name.** [5] **Place of publication,** [6] **Publisher,** [7] **Year,** [8] **Inclusive page numbers.** Do not omit digits.

Example: DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in Cardiovascular Medicine, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

Illustrations should be submitted in duplicate in an envelope (paper clips should not be used on illustrations since the indentation they make may show on reproduction). Legends should be typed, double-spaced on a separate sheet of paper. Photographic material should be high-contrast glossy prints. Patients must be unrecognizable in photographs unless specific written consent has been obtained, in which case a copy of the authorization should accompany the manuscript. All illustrations should be referred to in the body of the text. Omit illustrations which do not increase understanding of text. **Illustrations must be limited to a reasonable number** (four illustrations should be adequate for a manuscript of 4 to 5 typed pages.) The following information should be typed on a label and affixed to the back of each illustration: figure number, title of manuscript, name of senior author, and arrow indicating top.

Tables should be self-explanatory and should supplement, not duplicate, the text. Each should be typed on a separate sheet of paper, be numbered, and have a brief descriptive title.

Acknowledgments are the author's prerogative; however, acknowledgment of technicians and other remunerated personnel for carrying out routine operations or of resident physicians who merely care for patients as part of their hospital duties is discouraged. More acceptable acknowledgements include those of intellectual or professional participation. The recognition of assistance should be stated as simply as possible, without effusiveness or superlatives.

Galley Proofs will be mailed to the principal author for corrections. Reprint order forms will accompany galley proofs. ❑

Placement Service

OB/GYN

St. Jude Medical Center in Kenner, Louisiana is seeking **OB/GYNs** interested in solo or developing a group practice. St. Jude is a 300-bed facility located just 15 minutes from the New Orleans City Center. Kenner has become one of the areas most attractive residential communities.

The Hospital, constructed in 1985 offers attractive LDR suites, the latest in technology and a dedicated health care team. St. Jude Medical Center is also recognized as a leader in providing neo-natal services.

The group will be located in a seven-story, ultra modern Medical Office Building located on the campus of St. Jude. The Medical Office Building and Hospital are connected by a covered walkway. St. Jude can provide an attractive multi-year financial package for selected physicians as well as a comprehensive marketing program. To obtain additional information regarding this outstanding opportunity, please contact:

Mr. Woody Laughnan
Vice-President of Development
St. Jude Medical Center
180 West Esplanade Avenue
Kenner, Louisiana 70065
(504) 464-8090

IMMEDIATE !!!!! opening
for the right person.

If you are a **FAMILY PRACTITIONER** and are looking to have a more quality living & working environment with a **NET INCOME GUARANTEE** for the first year, take a look at what we can offer you!

Local hospital part of 16 hospital system, fully staffed and financially stable. Located between 2 recognized hospitals, in active community, with growing young families & stable economy experiencing a steady increase over the last 10 years. Fully equipped facility, offering practice support and excellent referral base.

State recognized under served area offering added income potential. For a confidential inquiry, contact **DONNA LANE, 800-362-5396, or FAX CV to 404/977-6518.**

MISSISSIPPI; GENERAL SURGERY- Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice w/coverage form surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician $150,000 net before taxes for 2 years. Wanda Parker 800-221-4762.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

INTERNIST

St. Jude Medical Center, a 300-bed, full service acute general hospital, located in Kenner, Louisiana has opportunities for **Internal Medicine Specialists.** The Hospital is seeking both solo practioners and physicians interested in developing a group practice. The city of Kenner is located just 15 minutes from Downtown New Orleans and is rapidly becoming one of the most popular residential areas in and around the City of New Orleans.

St. Jude, constructed in 1985 offers the latest in technology and patient care accommodations. Major services include cardiology, cardiovascular surgery, orthopedics, urology, neonatology and obstetrics and gynecology. The Hospital also provides skilled nursing and psychiatric care units.

Physicians relocating to the St. Jude campus can choose from attractive office space in the Medical Office Building located next door to the Hospital. The Office Building and Hospital are connected by covered walkway. St. Jude Medical Center provides an attractive relocation package including income guarantee, relocation assistance, practice development assistance and a strong marketing program. Interested physicians should contact:

Mr. Woody Laughnan
Vice-President of Development
St. Jude Medical Center
180 West Esplanade Avenue
Kenner, Louisiana 70065
(504) 464-8090

Items for the Placement Service should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

The advertising rate is $2.00 per line or $75.00 per 1/4 page block. Rate cards available upon request.

FP, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

Er Physicians Needed for North Alabama (urban communities). $130K plus all expenses. Accommodating schedules offered. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

FPs & IMs Desperately Needed in Birmingham, Montgomery, and Tuscaloosa. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.



Mississippi Opportunities

Great opportunities for Emergency Physicians in Mississippi. CES of Memphis, Inc. is dedicated to providing quality physicians in the following communities:

Canton, MS - 67-bed facility with annual ED volume of 12,000. Seeking Medical Director and independent contractors. 12 or 24 hour shifts. Remuneration up to $170,000 per year.

McComb, MS - New, state-of-the-art ED with 21,000 annual visits. Seeking physicians to practice as independent contractors. 160-bed facility with excellent medical staff. Very competitive fees.

For more information on these and other opportunities in Mississippi
call Wayne Allen at **1-800-777-1301**
or send CV to
CES of Memphis, Inc.
5885 Ridgeway Center Parkway, Suite 113
Memphis, TN 38120

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

RADIOLOGY POSITION
NO CALL! NO HASSLES!!

We seek a Radiologist to work 8-5, Monday-Friday serving two community hospitals in southern Georgia 2 1/2 hours for Atlanta. These hospitals work in cooperation with a 450-bed regional medical center and its outreach clinics. Extremely low overhead, no call, no hassles! Excellent income guarantee offered. Live in city of 120,000 or on nearby lakes or river. Only 2 hours from the Gulf beaches of Florida, Beautiful antebellum homes as sell as new construction available. CONTACT: Jeffrey Peebles, Tyler & Company, 1000 Abernathy Road, Suite 1400, Atlanta, GA 30328. Phone: 800-883-8803 or (404) 396-3939. Or fax CV to (404) 396-6693. All replies are confidential.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net Income of $150K, plus all expenses. Send CV to PO Box 6002, Tuscaloosa, AL 35405.

FAMILY PRACTICE

St. Jude Medical Center, a 300-bed, full service acute general hospital, located in Kenner, Louisiana has opportunities for **Family Practice physicians.** The Hospital is seeking both solo practioners and physicians interested in developing a group practice opportunity. The City of Kenner is located just 15 minutes from Downtown New Orleans and is rapidly becoming one of the most popular residential areas in and around the City of New Orleans.

St. Jude, constructed in 1985 offers the latest in technology and patient care accommodations. Major services include cardiology, cardiovascular surgery, orthopedics, urology, neonatology and obstetrics and gynecology. The Hospital also provides skilled nursing and psychiatric care units.

Physicians interested in joining the St. Jude team, can choose attractive office space in a seven-story, ultra modern Medical Office Building located on the campus. The Hospital and Office Building are connected by a covered walkway. St. Jude provides attractive income guarantees, relocation support and can offer a multi-year contract for physicians interested in developing a group practice. For further information regarding Family Practice opportunities here at St. Jude, please contact:

Mr. Woody Laughnan
Vice-President of Development, St. Jude Medical Center
180 West Esplanade Avenue, Kenner, Louisiana 70065
(504) 464-8090

MEA

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

MOONLIGHTING IN MISSISSIPPI



SINCE 1977, PRI-MED HAS BEEN STAFFING EMERGENCY DEPARTMENTS IN MISSISSIPPI, ARKANSAS, TENNESSEE, AND CALIFORNIA. PRI-MED OFFERS A WIDE RANGE OF OPPORTUNITIES FOR THE PHYSICIAN, FROM THE OCCASIONAL NIGHT SHIFT TO THE FULL-TIME EMERGENCY ROOM DIRECTORSHIP. FOR MORE INFORMATION ON MOONLIGHTING IN YOUR AREA PLEASE CALL JOE PAT JUNKIN OR PATSY MCDANIEL AT:

1-800-821-6382 - OUTSIDE TENNESSEE
1-901-685-9305 - IN TENNESSEE

Equal Opportunity Employer

PRI-MED
primary medicine

6263 POPLAR AVENUE, SUITE 700 • MEMPHIS, TENNESSEE 38119

$250K Guaranteed First Year for orthopaedic surgeon. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to P. O. Box 6002, Tuscaloosa, AL 35405.

FAMILY PRACTICE/ ER PHYSICIANS NEEDED FOR FILL-IN OR REGULAR PART-TIME BASIS AT A NORTH EAST JACKSON CLINIC. CALL 957-2273.

COMMENTS or QUERIES .....

The Editors of *Journal MSMA* invite you to comment on any material that appears in or is absent from the publication. If you have a query or comment, please sent it to:

The Editor, *Journal MSMA*,
PO Box 5229,
Jackson, MS 39296-5229.

Classified

Medical Laboratory Equipment For Sale : Hycell Counter 555 with Hct and MCV $1,000.00, Stat-Test System for glucose, pot, chol, & hgb $250.00, Junior Angle model 1600 centrifuge $150.00, #100 incubator $50.00. Call 601• 287-1453 or 601• 287-1202.

Medical clinic for a 1 to 3 physician occupancy. Equipped with supplies, furniture and instruments probably sufficient to institute immediate practice. Includes patient waiting area, 3 business offices, 9 examination rooms, 3 treatment rooms, lab, x-ray, staff lounge and storage rooms. **Located in downtown Moss Point,** an industrial city of 17837, with 2 rivers, Interstate 10 and airport within city limits. Adjacent to post office, banks, pharmacy. Ample parking. Convenient to Singing River Hospital. Contact Mrs. Barrett at John Jones and Associates. 1-800-748-8650.

Fiesta Charters - Captain Mike McRaney - Featuring the premier fishing experience on some of the most productive waters in the Gulf of Mexico. Call **FIESTA CHARTERS, Captain Mike McRaney, (601) 875-9462, PO Box 999, Biloxi, MS, 39533.**

Retail or Office space available, excellent location, between Woman's Hospital and River Oaks Hospital, Jackson, MS, will remodel. Space available: 1,100 or 4,500 sq. ft. also 1,150 sq. ft. of office space. Call 939-0607.

Items for the Classified Section
should be sent to the Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.
The advertising rate is $2.00 per line or $75.00 per 1/4 page block.
Rate cards available upon request.

Index to Advertisers

Avanti 410

CancerPay Plus 400
CompHealth 405

Deposit Guaranty Investments 406
Disability Determination 420

Eli Lilly & Co. - Humulin **4**
Employer Plus, Inc. ..... **403 & 414**

Medical Assurance Co. of MS **8**
Medley & Company 411
MS Emergency Association 421
MS Methodist Rehabilitation Center ..... **second cover**
MS Physicians Insurance Company 412
MSMA Benefit Plan & Trust 415

Premier Printing 397
PRI-MED, Inc. 421

Searle - Calan SR ..... **fourth cover**
St. Dominic Hospital **6**

The Doctors' Company ..... **third cover**
Trustmark 399

US Air Force 408
US Army Active 402



Photo courtesy of the Mississippi Department of Economic and Community Development.

Placid. Peaceful. Protected.

Putting your mind at ease so you can concentrate on providing the best health care for your patients. As the nation's largest doctor-owned, doctor-managed professional liability insurer, The Doctors' Company works with over 16,300 member physicians, helping them reduce losses and improve patient care.

We're here to protect the professional environment of Mississippi physicians. The Doctors' Company is helping good doctors practice better medicine.

If you're not already a member, call The Doctors' Company today.

LIBRARY
NOV 2 4 199?
NY Academy of Medicine

(800) 898-0373

THE DOCTORS' COMPANY

The Doctor-Owned Doctor-Managed Professional Liability Specialists.

Represented in Mississippi by: Sampson Howard & Ashcraft
Bill Howard
(800) 530-7598 (National) • (601) 956-3720

For the many faces of mild hypertension

MILD



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION[1]*

- Effective 24-hour control[2]
- Single-agent efficacy
- Well tolerated†
- No adverse effects on total cholesterol, plasma glucose levels, renal function,‡ or serum electrolytes[3-6]

ONCE-DAILY

Calan® SR

verapamil HCl

SUSTAINED-RELEASE CAPLETS

120 mg

180 mg

240 mg

For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-1SI. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;7S:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:102S-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

2/13/92 • P92CA7196V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific Information Department
4901 Searle Parkway
Skokie, IL 60077

© 1992 Searle

P92CA7233T

SEARLE

Box 5110
Chicago, IL 60680-5110

JOURNAL

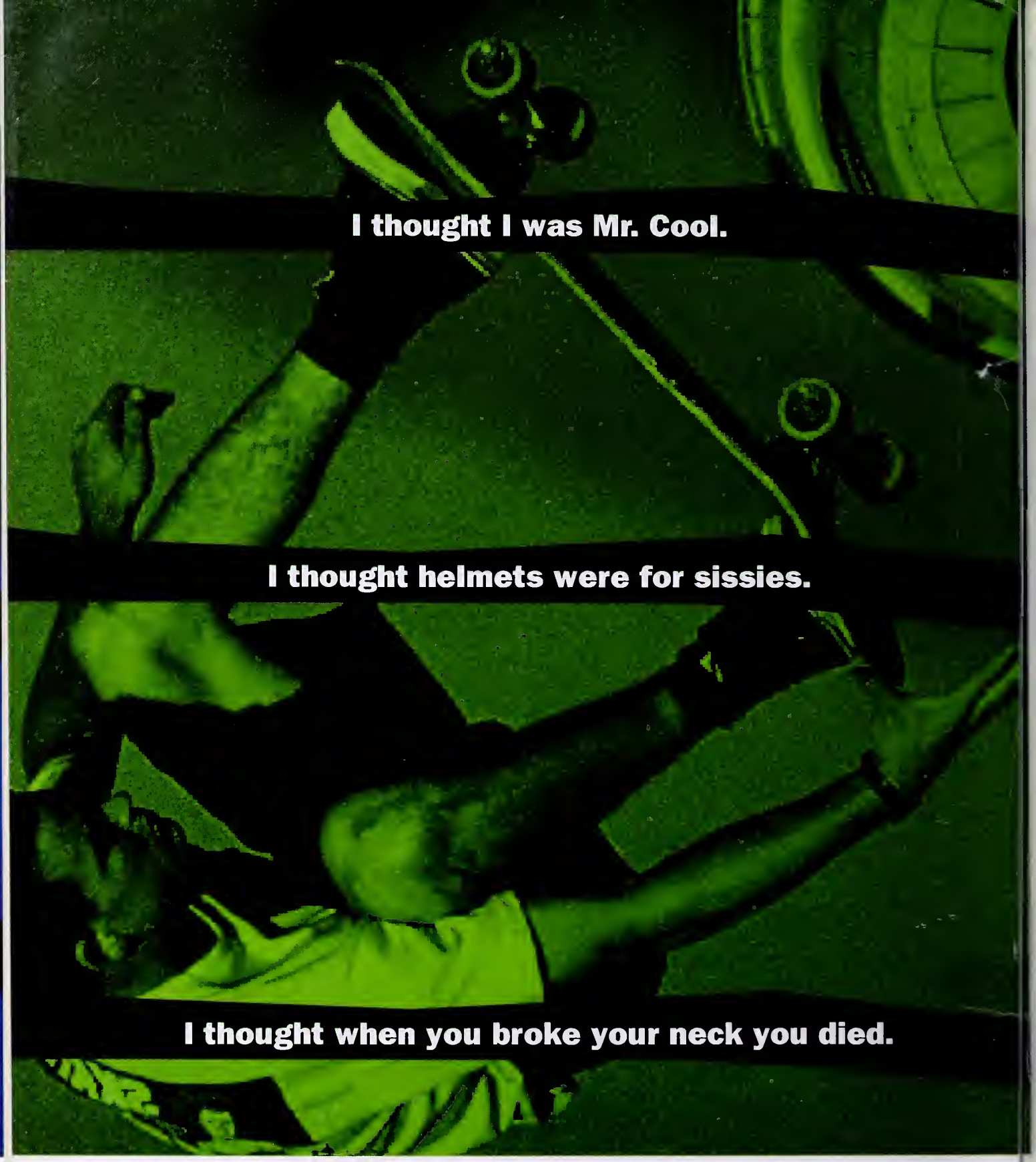
OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

DECEMBER 1992



YEAR END INDEX

1992



Most kids think traumatic brain and spinal injuries only happen to other people. But last year alone, almost half a million kids thought wrong. We need your help. Call MMRC today at 1-800-223-6672. Ask about our safety awareness program. Because if you think it can't happen to someone you love, you better think again.

MMRC
MISSISSIPPI METHODIST REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, MS 39216
(601) 981-2611 or 1-800-223-6672

JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

DECEMBER 1992 VOLUME XXXIII NUMBER 12

SCIENTIFIC ARTICLE

Vertical Banded Gastroplasty: Is Obesity Worth It? 423
Richard J. Field, Jr., MD, FACS; Richard J. Field, III, MD and Sue Y. Parks

EDITORIALS

"Practicin' Medicine Ain't No Fun Anymore...." 434
William C. Gates, Jr., MD

MFMC Works For You 435
George E. Abraham, II, MD

Are Doctors Respecting Living Wills? Is The Intent Too Poorly Expressed 435
W. Moncure Dabney, MD

DEPARTMENTS

Current Opinions 437
Medical Organization 439
New Members 445
Personals 447
Placement Service 458

EDITOR
Myron W. Lockey, MD

EDITOR EMERITUS
W. Moncure Dabney, MD

ASSOCIATE EDITORS
George E. Abraham, MD
Joseph E. Johnston, MD

MANAGING EDITOR
Virginia Lee Cocke

PUBLICATIONS COMMITTEE
Richard C. Miller, MD, *Chairman*
William E. Godfrey, MD
Leslie E. England, MD
and the editors

THE ASSOCIATION
William C. Gates, MD, *President*
Don Q. Mitchell, MD, *President-Elect*
D. Stanley Hartness, MD, *Secretary-Treasurer*
H. Vann Craig, MD, *Speaker*
Eric A. McVey, III, MD, *Vice Speaker*
Charles L. Mathews, *Executive Director*

NATIONAL ADVERTISING BUREAU: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Illinois 60302. Phone 708/383-8800.

Copyright© 1992, Mississippi State Medical Association. The views expressed in this publication reflect the opinions of the authors and do not necessarily state the opinions or policies of the Mississippi State Medical Association.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (ISSN 0026-6396) is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $35.00 per annum; $45.00 per annum for foreign subscriptions; $3.00 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi, 39296-5229.



Photo courtesy of the Mississippi Department of Economic and Community Development.

Placid. Peaceful. Protected.

Putting your mind at ease so you can concentrate on providing the best health care for your patients. As the nation's largest doctor-owned, doctor-managed professional liability insurer, The Doctors' Company works with over 16,300 member physicians, helping them reduce losses and improve patient care.

We're here to protect the professional environment of Mississippi physicians. The Doctors' Company is helping good doctors practice better medicine.

If you're not already a member, call The Doctors' Company today.

(800) 898-0373

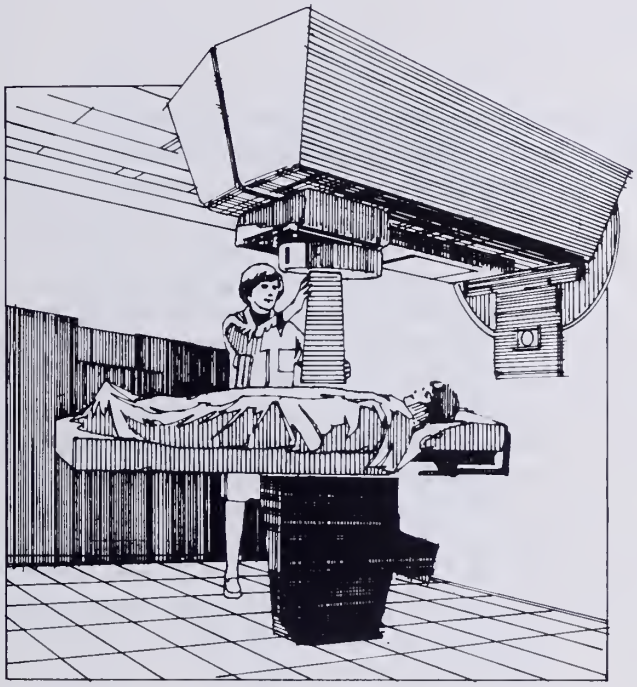
THE DOCTORS' COMPANY

The Doctor-Owned. Doctor-Managed Professional Liability Specialists

Represented in Mississippi by: Sampson Howard & Ashcraft
Bill Howard
(800) 530-7598 (National) • (601) 956-3720

Now available to Mississippi State Medical Association members, protection from one of America's leading diseases ..... **CANCER.**

"CANCERPAY PLUS"



- "CancerPay Plus" is a quality cancer policy supplement to your present health insurance.
- Offered by the Mississippi State Medical Association, "CancerPay Plus" provides excellent benefits to physician members of MSMA, their employees and families.
- Reduced rates through Association affiliation.
- Payroll deducted with groups as small as one participant.
- Pays in addition to all other insurance, including Medicare.
- Intensive Care and Dread Disease riders available.

For Complete Details of Plan Call or Write:

Scott Shappley
MISSISSIPPI STATE MEDICAL ASSOCIATION
P.O. Box 55509
Jackson, MS 39296-5509
(601) 354-5433 — Watts 1-800-898-0251

Dateline

Journal of the Mississippi State Medical Association
Volume XXXIII, Number 12

Adolescent Pregnancy and Its Public Costs Increase

Jackson , MS (AP) - Mississippi dishes out 100 times more money dealing with the outcome of adolescent childbirth than it spends on stopping teenage pregnancies, a survey of 17 Southern states shows.

That finding was reflected across the region by the Adolescent Pregnancy in the South report by the Southern Regional Project on Infant Mortality. As the number of babies born to adolescent increases annually, so do the public costs of supporting families started by adolescents.

"This problem costs us a lot of money. We don't provide much prevention," said Oklahoma Governor. David Walters, who helped initiate the project.

Mississippi spent more than $220 million in Medicaid, food stamps and child support to families begun by adolescent parents in 1991. About $2.3 million went to education and resources geared to prevention last year.

The Southern states spent about $5.73 billion in support and $110.3 million on prevention in 1991 and 1992, respectively, Walters, said. "You hear a lot about the personal costs of teen-aged parenthood, but the public pays a price too. It is not just the young families, but each of us who bears the burden, and we will continue to until we focus greater emphasis on policies, programs and funding to help delay early parenthood."

***

State Receives $65,226 Grant For Immunization Program

Jackson, MS - Modest funds from a private foundation could help make Mississippi the first state to reach 90-percent immunization among preschool children, a state official said.

The state Department of Health is one of 23 agencies nationwide to receive a grant under the Robert Wood Johnson Foundation's All Kids Count initiative.

The $65,226 received this week from the nation's largest health-care philanthropy will be used to develop a comprehensive plan for assuring immunization of preschoolers.

With a 70 percent immunization rate in 1992, Mississippi ranks ahead of most states. "It's not good enough," said State Epidemiologist Dr. Ed Thompson. "Our major goal is to develop a system to increase immunization in Hinds County that could be used elsewhere in the state."

A handful of states are in a position to reach the national objective of 90 percent immunizations by 2000, he said. Mississippi intends "to reach the objective first," he said.

The vaccines immunize against measles, mumps, rubella, polio, diphtheria, tetanus, whooping cough and Haemophilus Influenzae B.

The grant will pay for developing a system to help private pediatricians and the Health Department track children as they come due for immunizations.

UMC Awarded Grant

Jackson, MS - UMC has been awarded an $8,000 cooperative grant to launch a safety belt education project for teenage drivers. Funded by the Mississippi Department of Rehabilitation Services and the Centers for Disease Control, the project will begin in November. Dr. Michael Bross, associate professor of family medicine and director of community and rural medicine, will direct the project.

"Automotive-related deaths are the No. 1 killer of teenagers. A lot of those deaths are preventable," Dr. Bross said. "When this project is complete, we hope more students will wear safety belts."

According to state studies, less than 25 percent of Mississippi motorist wear safety belts. Lap and shoulder belt use reduces the risk of injury and death by 45 to 50 percent, Dr. Bross said.

UMC's trauma service and the occupant Restraint Project of the University of Southern Mississippi also will work with the project.

***

125th Annual Session Scientific Exhibits

The MSMA 125th Annual Session will be held April 28 - May 2, 1993 at the Royal d'Iberville Hotel, Biloxi. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or FAX this information to (601) 352-4834. The letter requesting exhibit space should include the following information:

(1) the title of the exhibit;
(2) the author(s) of the exhibit;
(3) an estimate of the amount of exhibit space needed; and
(4) a brief synopsis of the subject to be exhibited.

***

MSMA Community Service Award Nominations

Information has been sent to all Component Society presidents and secretaries soliciting nominations for the 1993 MSMA Community Service Award. The award is designed to provide recognition to members of the association, who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities. The award consist of an engraved plaque and a $500 contribution made by the association to the civic organization designated by the award recipient.

The MSMA's Council on Public Information encourages each component society to submit a nominee for this award. All nominations should be submitted by January 15, 1993 and the award will be presented during the MSMA's 125th Annual Session.

***

MSMA Annual Socio-economic Forum

The MSMA Socio-economic and Legislative Forum will be held January 19, 1993 at the Ramada Coliseum Hotel, Jackson, Mississippi. A new administration, a 103rd Congress and a redistricted, newly-elected Mississippi Legislature will all begin in January and will be discussed during this Forum.

THERE *IS* INSURANCE FOR THE UNINSURABLE.

You see them most every day — patients who, because of an injury, chronic illness or congenital disease, cannot find an insurer to cover their medical expenses. They are left to pay their bills any way they can. It's a burden on them. It's a burden on you.

Now there is a solution.

The Mississippi Comprehensive Health Insurance Risk Pool Association offers a comprehensive major medical benefits plan to Mississippians who can otherwise afford insurance but are unable to obtain it due to health conditions.

Operational since January, 1992, the policy offered by the Risk Pool Association contains a maximum benefit of $250,000 and a choice of yearly deductibles of $1,000 or $2,000. There is a one-year pre-existing condition limitation.

You can make a difference.

Since the program is new, its benefits are not widely known. You can help spread the word. If you have patients who cannot obtain health insurance because of injury, chronic illness or congenital disease, have them contact their local insurance representative or the Risk Pool Association. The Association benefit plan is administered by Blue Cross & Blue Shield of Mississippi.

If you have any questions about the Mississippi Comprehensive Health Insurance Risk Pool Association, call Lanny Craft at **(601) 362-0799**.

MISSISSIPPI
COMPREHENSIVE
HEALTH INSURANCE
RISK POOL ASSOCIATION

P.O. Box 13748 • Jackson, MS 39236-3748

Vertical Banded Gastroplasty: Is Obesity Worth It?

RICHARD J. FIELD, JR., MD, FACS
RICHARD J. FIELD, III, MD, FACS
SUE Y. PARK, BA

Obesity is a public health issue of major concern for the United States and other developed nations. In the last several decades, bariatric surgery has developed as a means of treating morbid obesity. Vertical banded gastroplasty (VBG) is an attractive procedure because it has fewer side effects than other forms of bariatric surgery and maintains physiological continuity of the gut. VBG was performed in 36 patients at a rural community hospital from 1982-1990. There was only one intraoperative complication necessitating splenectomy and two early postoperative complications — gastric leak and marginal stress ulcer — necessitating reexploration. Twenty-five patients were available for follow-up, at which time they were an average of 6.4 years out of surgery. Two of these patients had died, both from cardiac arrest months or years after VBG. The remainder had gone from a preoperative average of 86.7% over ideal weight according to 1983 Metropolitan Life Insurance Tables to 54.5% over ideal weight. Mean BMI for this group had changed from 41.2 preoperatively to 34.7 at follow-up. Success was defined as weight loss to < 60% over ideal or BMI < 35, removing the individual from the morbidly obese category. According to this criteria, VBG provided successful weight loss in 72% of subjects in the follow-up group. Weight loss results may have been biased as a significant number of patients were lost to follow-up and may have constituted failures. In general, most individuals did not make concomitant changes in diet or sedentary life-style which would have supported weight loss effected by VBG. Moreover, regain of weight was progressive and possibly inexorable. Nearly all individuals nonetheless reported great satisfaction with their surgery. VBG is a viable option in the treatment of morbid obesity, but criteria for success needs to be better defined in order to determine whether the procedure is "worth it."

Obesity is a problem of complex genetic and biobehavioral etiology.[1-4] It is a serious public health issue of increasing prevalence in the United States and other industrialized nations.[5] At least 50% of middle-aged Americans are obese[6] and 25% of children and adolescents.[4] Overweight individuals typically give a family history of obesity, engage in overeating and impulsive eating, and lead sedentary lifestyles. The morbidly obese are physically disabled by their weight and discriminated against by employers and insurance companies, adding the obese to already crowded welfare rolls.[7] Excess weight predisposes to hypertension, late-onset diabetes, osteoarthritis, infertility, hepatobiliary disease and cancer of the endometrium, cervix, breast, prostate, gallbladder and colon.[8-10] The obese are also at increased risk of accidental death from decreased alertness, mobility, and increased vulnerability to unforeseen physical dangers.[10,11] For these reasons, mortality for the obese is exponentially higher than that of the general population. Unfortunately, obesity is extremely difficult to treat, and

intractable in the long run to fasting, behavior modification, hypnosis and other non-operative forms of therapy. [8, 12, 13]

Operations to treat obesity were developed and have been shown to provide better long term results.[14] Early proponents of bariatric surgery popularized intestinal bypass, which has since fallen into disrepute secondary to side effects of malabsorption. Many explored gastric reduction for obesity, looking for similar success in weight loss while maintaining the physiological integrity of the bowel. In 1982, Mason published results of a specific modification of gastroplasty called vertical banded gastroplasty (VBG) in which a small proximal gastric pouch is created which empties via a small, reinforced stoma into the distal stomach.[15] Satiety is produced after consumption of a limited quantity of solid food. Following Mason's technique. VBG's were performed on a total of 36 patients at the Field Memorial Community Hospital between 1982-1990. Seven of these procedures were revisions of prior surgery for obesity.

Table 1
Preoperative Patient Characteristics

	Total VBG	Primary VBG	Revision to VBG
Sample Size	N =36	N =29	N =7
Mean Age	36.7 years	-	-
Sex Ratio (M:F)	1:17	-	-
Mean Weight (lbs)	216	261	203
Mean % over Ideal Weight*	86.7%	94.6%	54.0%
Mean BMI**	41.2	43.6	31.3

* As calculated from 1983 Metropolitan Life Insurance Ideal Weight Tables for a medium frame individual [8,16]
** Body Mass Index = weight (kg)/height2(m)

METHODS

Patient Selection

As the table below indicates, the patient population was largely composed of middle-aged females (range in age: 17-61 years), approximately 87% over Ideal weight with mean BMI values over 40, placing these individuals well within criteria for morbid obesity. All patients had made repeated prior efforts to lose weight through dieting and use of anorexigenic medications.

Women comprise more than 80% of patients who undergo surgery for morbid obesity.[22] Women's magazines and other popular media promulgate an obsession with thinness and with overall physical appearance in females. It is in response to the social pressure that women, more than men, are driven to seek surgical treatment for obesity (see Table 1).[31]

Definition of Obesity

Body Mass Index (BMI) is a measure of degree of obesity with a high correlation with direct measures of body fat. It is simple to calculate and obviates constant referral to ideal weight charts. BMI values from 15 to 25 concur with desirable weight range according to insurance statistics. A 1985 NIH Consensus Conference determined that weight only 20% over ideal (according to 1983 Metropolitan tables), correlating with BMI values of 27.2 for men and 26.9 for women, is associated with sufficient risk to health to warrant clinical intervention.[16] Mortality increases markedly when BMI values rise above 30 and mortality in fact triples at a BMI approaching 40. "Morbid" obesity has been defined as a BMI over 35[8] and $\geq$ 40 by others.[17,18] Arbitrarily, morbid obesity has also commonly been defined as an excess weight of 100 pounds or more above ideal weight. This is not accurate, as 100 pounds overweight for a 5 foot individual implies greater obesity than the same amount of overweight for a 6 foot individual.[8] Insurance statistics are difficult to obtain for the morbidly obese as they are often denied coverage; however, independent studies have described six- to twelve-fold increases in mortality for this group.[8,11,18]

All patients receiving VBG primarily meet the above criteria for "morbid" obesity. Success of the procedure is defined as weight loss to a BMI < 35 or an average weight under 60% over ideal, at least removing the individual from the "morbidly obese" category by anyone's standards.

Operative Procedure

The technique is as described by Mason.[15] A nasogastric tube measuring 1 cm. in external diameter was passed into the stomach. Either a longitudinal or Chevron incision was then made, exposing the esophagogastric junction which was dissected free and isolated with a Penrose drain. A window was made in the lesser omentum and the posterior wall of the stomach dissected free from the aorta and pancreas, creating a 7 cm. tunnel from the lesser curvature to the esophagogastric His' angle. The EEA stapling device was used to remove a 25 mm. diameter circle of tissue from the anterior and posterior walls of the stomach just lateral to the n-g tube lying along the lesser curvature. The

EEA staple line was oversewn with interrupted 4-0 Dexon sutures. The TA90 stapler was then placed in a vertical direction to the angle of His through the circular aperture and the previously formed tunnel along the posterior wall of the stomach. The TA90 stapler was applied twice, leaving 4 rows of staples. A 20 cc. pouch was created with a 1 cm. outlet stoma emptying into distal stomach. A Marlex mesh band 1 cm. in width was wrapped around the stoma and sutured to itself with two interrupted 00 Dacron sutures. Omentum was brought over the Marlex mesh to prevent adherence to the liver (see Figure 1).

Types of procedures converted to VBG included 2 jejunoileal bypasses, 4 horizontal unbanded gastroplasties and 1 vertical unbanded gastroplasty. Failed gastroplasties, allowing regain of most or all weight, all involved dilatation of the proximal pouch, the outlet stoma or both. Subjects consistently describe being able to eat as much solid food as the wanted at one sitting. Because this happens so frequently in horizontal unbanded gastroplasties (e.g. Gomez and Pace procedures), these operations have been abandoned despite ease of operation and low complication rate.[12,14,15,19,20,21] Intestinal bypasses were not failures in terms of weight loss, but were associated with other unacceptable side effects such as short bowel syndrome with intractable diarrhea, pruritus ani and recurrent electrolyte abnormalities.[22]

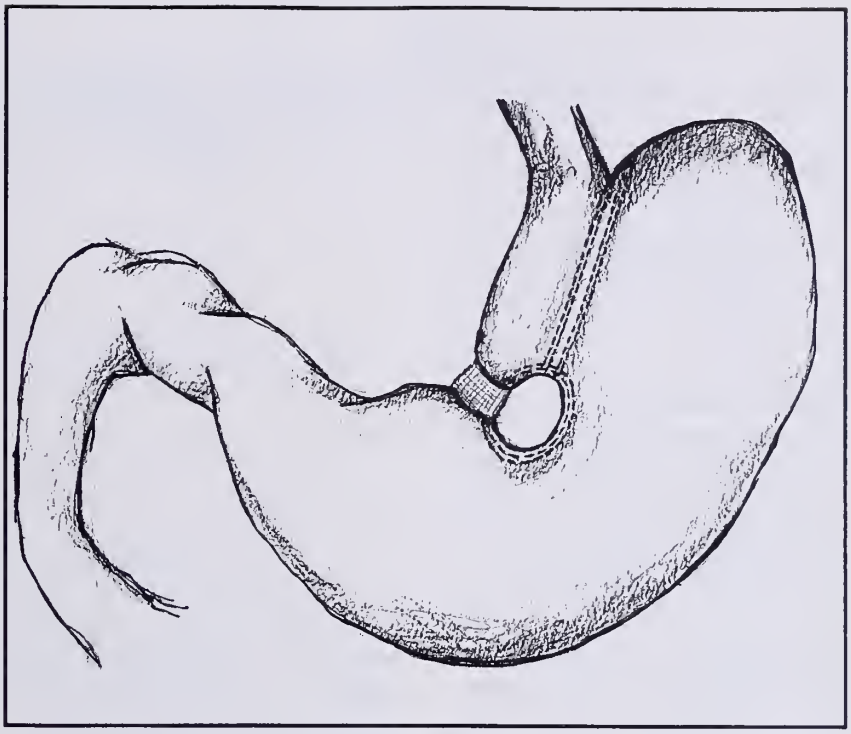


Figure 1 — Vertical banded gastroplasty. A proximal gastric pouch is created with an outlet stoma banded by Marlex mesh. Note that physiological continuity of the digestive tract is maintained.

Post-operative Care and Follow-up

Postoperatively, patients were instructed by the dietician to stay on a liquid and soft or pureed food diet for two months. Patients were to eat no more than three times a day with low calorie snacks in between. Once advanced to a regular diet, patients were advised to chew slowly and cut food into small pieces. Multivitamin supplements with zinc and iron were initially prescribed, but this was discontinued as patients complained of unpleasant tasting "metallic" eructations. Regular follow-up was encouraged; however, all patients failed to keep clinic appointments after the first year beyond surgery.

Twenty-three patients out of 36 who had undergone VBG between 1982-1990 were interviewed by telephone in February, 1992. Two patients has died. The remaining 11 patients had moved and were unavailable for follow-up. Data on height and weight may be inaccurate as it was obtained via telephone interview rather than office visit and previous studies have shown that self-reported height and weight show modest errors that increase with increasing body weight.[23] In fact, one subject in the study was hesitant to be interviewed with the fear that her regained weight would "get me in trouble." This bias is felt to have been operating in the 1959 Metropolitan Life Insurance Ideal Weight Tables, leading to their revision in 1983.[6] Different studies have demonstrated conflicting results on how failure to follow-up may skew weight loss data. Some show that those patients who fare poorly also fail to keep appointments,[24,25] while others show that patients who feel they are doing well see no need for continued follow-up.[22] Weight loss is evaluated as percent over ideal weight on follow-up rather than as percent of preoperative weight or percent excess weight lost. These latter measures lead to less stringent definitions of success in the heaver morbidly obese patient and do not allow accurate assessment of decreased mortality according to insurance statistics.

Patients were asked to recall the previous day's intake of food and questioned on other issues such as employment status, satisfaction with

Table 2
Postoperatie Complications After VBG

	Primary VBG	Revision to VBG
Early complications*		
Gastric leak	1	-
Perforated stress ulcer	1	-
Wound problems	5	-
Atelectasis	1	-
Ileus	-	1
Vomiting	-	1
Late complications**		
Incisional hernia	5	1
Electrolyte imbalance	-	1

* within 90 days of surgery
** more than 90 days after surgery

the procedure and acceptance of pre- and postoperative appearance by family and friends.

RESULTS

Postoperative complications

Average length of operation was 1.5 hours in VBG performed primarily, while revision to VBG took an average of 2.8 hours. Average length of hospitalization was 5 days (range: 4-19 days) whether the VBG was performed primarily or as a revision. Length of stay reflected early postoperative complications which were not more likely to occur in those undergo-ing revision to VBG. The only intraoperative complication in this series of patients was a splenic laceration necessitating splenectomy (see Table 2).

Both the gastric leak and stress ulcer comprised major early complications necessitating re-exploration, and removal of the Marlex band in one case. Wound problems included minor superficial infections, partial dehiscence and one episode of wound bleeding. The one patient with electrolyte imbalance had undergone revision from jejunoileostomy to VBG and had had electrolyte derangements prior to surgery. Vomiting was only noted in the patient with post-operative ileus. Unlike horizontal gastroplasty or gastric bypass, VBG is not ordinarily complicated by vomiting, which can lead to malnutrition. Moreover, VBG maintains physiologic continuity of the gut, theoretically preventing malabsorption. Nonetheless, MacLean et al note that one year after VBG, a significant number of patients had an abnormal reduction in vitamin B-12, red blood cell folate and serum iron.[16] Although this was not associated with a clinical deficiency syndrome, it underscores the need for monitoring.

Late complications encountered in this series of patients will be underestimated as only 25 out of the initial 36 patients could be followed to this date. It is interesting to note that out of the 6 incisional hernias picked up as late complications, 4 occurred in those who had longitudinal incision, while two occurred in patients who had received a Chevron type incision. Theoretically, the Chevron incision is less subject to dehiscence or hernia as may be corroborated by our series. The Chevron incision also provides better intraoperative exposure.

On the average, patients followed up in 1992 were six years out of surgery (range: 2-10 years). Eight out of the 29 patients who underwent VBG primarily were lost to follow-up. Another subject had an *un* banded gastroplasty after early postoperative complications dictated removal of the Marlex mesh band to control intraabdominal infection. This patient was removed from the sample. Finally, two out of 29 subjects were deceased, leaving a sample size of 18 primary VBG patients at follow-up. Of the two patients that died; one had a massive heart attack at age 61, months after surgery. The subject had a past medical history of hypertension. The other died of cardiac arrest shortly after surgery for endometrial cancer, stage II. The patient was 58 years old and had a history of both hypertension and diabetes. Women 40% or more overweight are 5 times more likely to die from endometrial carcinoma than women of average weight.[9]

Weight Loss

Most subjects who had undergone VBG primarily lost weight very rapidly immediately after surgery, with maximal weight loss within two years after surgery. At, or less than, two years postoperatively, these individuals reported a mean BMI of 30.9 and were 37.9% overweight compared to preoperatively when the BMI averaged 43.6 and subjects were 94.6% overweight (or at least 100 pounds over ideal weight). Although all primary VBG subjects regained weight in subsequent years, current follow-up still demonstrated improvement over preoperative weight and with a mean BMI value of 34.7 and average overweight of 54.5% over ideal. These results are similar to those obtained by Mason et al at five-year follow-up on a larger series of patients (n=260) (see

Table 3
Postoperative Patient Characteristics

	Primary VBG 1992	Primary VBG ≤y. postop	Revision to VBG 1992
Sample Size	n=18	n=17	n=4
Mean # Years After VBG	6.4	-	5.8
Mean % over ideal Weight*	54.5	37.9	88.0
Mean BMI**	34.7	30.9	42.9

* As calculated from 1983 Metropolitan Life Insurance Ideal Weight Tables for a medium frame individual[8,16]
** Body Mass Index = weight (kg)/height2(m)

Table 4
Differentail Weight Loss By Years After Primary VBG

	2-5 years postop	6-10 years postop
Sample Size	n=8	n=11
Mean % over Ideal Weight*	53.0	61.4
Mean BMI** 34.4 36.1		

* As calculated from 1983 Metropolitan Life Insurance Ideal Weight Tables for a medium frame individual[8,16]
** Body Mass Index = weight (kg)/height2(m)

Table 5
BMI <35 Before and After VBG

	Primary VBG	Revison to VBG
Preoperative Sample Size	1	3
Postoperative Sample Size	14	2
Total n=22		

Table 3).[27]

When weight loss among primary VBG subjects was broken down into two groups, those who were 2-5 years out of surgery at follow-up had regained less weight than those 6-10 years out of surgery. These results highlight the progressive nature of weight gain after surgery (see Table 4).

Three out of the 7 patients who had undergone revision of previous bariatrics surgery were lost to follow-up, leaving a sample size of only 4. There is a marked difference in postoperative outcome after VBG done primarily versus as a revision. Individuals in the revision group who had initially been less obese than those in the primary VBG group, were now much heavier at follow-up. Postoperatively, they demonstrated a mean BMI of 42.9 and average overweight of 54% over ideal. These results are dismal is contrast to those obtained for subjects undergoing VBG primarily. These results are also markedly worse than those reported by other converting prior bariatrics procedures to VBG.[28] One individual who had had intestinal bypass revised went from a preoperative weight of 260 pounds to 500 pounds! This suggests that individuals undergoing revision from intestinal bypass to VBG may require more intensive counseling as they need to make behavioral changes in food intake and exercise in order for the gastric stapling to work — changes which were not required with jejunoileostomy for effective weight loss. Of small comfort is that all side effects of intestinal bypass resolved with conversion to VBG (see Table 5).

When results for individuals are examined rather than mean values for the group, results are still encouraging for the primary VBG group and less so for the revision group. In the primary VBG group (n=18), only one patient was noted preoperatively to have a BMI < 35. Following surgery, 14 patients had a BMI < 35, describing a change in status for 72% of the group to a non-morbidly obese category. In the revision group (n=4), *more* individuals were noted to be morbidly obese after VBG than before.

Associated Medical Problems

Obesity-related medical problems in this sample of patients included hypertension, diabetes, arthritis, hypercholesterolemia, infertility and shortness of breath with minimal exertion. According to the second National Health and Nutrition Survey (1976-1980), hypertension, hypercholesterolemia and diabetes were strongly associated with BMI values greater than or equal to 27.8 for men and 27.3 for women.[16] In a preoperative sample size of only 36 patients, 17 (47%) reported having hypertension and 10 (28%) as having diabetes while one had hypercholesterolemia and hyperlipidemia by lab values (see Table 6).

Out of those patients followed,

Table 6
Associated Medical Problems Before and After VBG

	Before VBG (n=36)	After VBG (n=22)	
	# of Patients (%)	# of Patients Followed	# Improved (%)
Back, Joint Pain	25 (69%)	14	7 (50%)
Hypertension	17 (47%)	12	5 (42%)
Diabetes	10 (28%)	5	2 (40%)
Exertional Dyspnea	10 (28%)	3	2 (67%)
Irregular Menses/ Infertility	2 (6%)	2	1 (50%)
Hypercholesterolemia	1(3%)	1	0 (0%)

which comprises a significantly smaller population that the original, a large number reported improvement or complete resolution of medical problems after weight loss with VBG. However, the relationship between actual weight loss and amelioration of disease is unclear. For example, those subjects describing complete resolution of their hypertension lost a greater amount of weight but were still more overweight with a higher BMI than their counterparts who were still hypertensive. In contrast, diabetic patients with improved glucose levels after VBG were both closer to ideal weight and had lost more weight than their counterparts. Resolution of back and joint pain was not related to either amount of weight lost or actual degree of overweight at follow-up.

Food Intake

Patients were questioned with respect to satiety after eating. Fifteen patients (68%) reported they still could not eat as much at one sitting as they could prior to VBG. This group averaged 47.7% over ideal weight with a mean BMI of 33.3. In comparison, the 7 patients (32%) who described themselves as being able to eat as much as they wanted to averaged 88.5% over ideal weight with a mean BMI of 42.5. This may in large part be due to staple line disruptions, as enlargement of the banded portion of the gastroplasty is rare (see Table 7).[26]

The group that reported satiety after a fairly small meal is still significantly obese, however. Quantitative restriction of food intake will fail to result in weight loss if quality of food or frequency of eating undermines it. One subject described herself as an "emotional eater." Schlundt et al. showed a significantly increased probability of overeating and impulsive eating in subjects reporting fatigue, boredom, irritability and depression, while hunger was actually associated with *lower* probability of overeating and impulsive eating.[3] Drenick has also described the disassociation of hunger and eating in the morbidly obese and characterizes the obese as food addicts.[10]

Subjects were assessed on ingestion of high fat food, junk food and sweetened beverages to gauge qualitative aspects of their diet (see Table 8).

Subjects were regarded as having high fat diets if in their recall of items eaten the day before interview, items high in saturated fats were consumed at two separate meals. Typical menu items included fried fish, fried chicken wings, french fries and sausage. Those subjects included in the junk food category reported significant amounts of snacking on potato chips, candy bars, etc. Subjects drinking sweetened beverages included iced tea drinkers and one subject who routinely drank two six packs of regular Coca Cola a day. Patients in the category reporting "none" of the above qualitative factors in their diet were markedly less obese on average than their counterparts. Others have reported similarly on adverse effects of dietary indiscretion on weight loss after VBG.[12,29]

All told, the majority of patients in this study failed to make qualitative dietary changes conductive to weight loss. One patient followed-up who would have been placed in the "none" category was excluded secondary to doubts regarding veracity of dietary intake. This patient weighed 500 pounds and insisted that a piece of broiled chicken and one cup of butter beans with diet soft drinks represented his usual daily intake.

Interestingly, when asked if they could eat anything they wanted, many subjects (68%) spontaneously

Table 7
Quantitative Aspects of Diet After VBG

	Limited Intake	Unlimited Intake
Sample Size	n=15	n=7
Mean % over Ideal Weight*	47.7	88.5
Mean BMI**	33.3	42.5

* As calculated from 1983 Metropolitan Life Insurance Ideal Weight Tables for a medium frame individual[8,16]
** Body Mass Index = weight (kg)/height2(m)

Table 8
Qualitative Aspects of Diet After VBG

	High Fat	Junk Food	Sweetened Beverages	None
Sample Size (% Total)*	n=12(55%)	n=8(36%)	n=11(50%)	n=5(23%)
Mean % over Ideal Weight **	61.7	65.6	60.3	31.1
Mean BMI***	36.3	37.3	36.0	29.9

* n=21
** As calculated from 1983 Metropolitan Life Insurance Ideal Weight Tables for a medium frame individual[8,16]
*** Body Mass Index = weight (kg)/height2(m)

mentioned difficulty tolerating meat — chicken, beef, pork — especially unprocessed meat. Sandwich spreads, ham, fish and seafood usually ingested without much problem. In the patient who has problems regulating intake, it is possible that fresh foods and meats which may require longer digestion are considered intolerable because they limit intake. VBG may encourage increased consumption of processed foods which tend to be higher in saturated fat, complex sugars and sodium content. Owen, et al have also noted intolerances to food such as red meat, bread and fruit and subsequent constipation due to inability to take dietary fiber.[32]

Exercise

Only 45% of patients followed-up indicated that they were on any sort of exercise program, or, as some stated, getting their exercise at work. Mean BMI for these individuals was 32.1 with average overweight of 55.8% over ideal. The remaining subjects who stated they did no exercise at all were not much heavier than those exercising, with mean BMI for the group of 37.0 and average overweight of 64.7% over ideal. Perhaps the definition of what subjects considered "exercise" needs to be examined. In the three individuals who were attending gyms to use weight-lifting machines or participate in aerobic, mean BMI was markedly lower at 27.5 with average overweight of 22.3% over ideal. It would appear that exercise formally engaged in at a gym is correlated with improved weight loss and may simply reflect increased motivation on the part of the individual.

Employment Status

Hawke et al describe marked increase in employment, full or part-time, after gastric reduction.[30] In our series of patients 50% were employed prior to VBG. At follow-up, 64% were employed, the increase in part due to people who had previously been Medicaid recipients and who were motivated by weight loss to seek employment. However, there were just as many if not more subjects who remained unemployed despite weight loss. Many of these individuals were housewives. The actual amount of weight loss had little bearing on subsequent employment status (see Table 9).

Yale and Weiler, in a study involving a larger series of patients undergoing VBG (n=200) noted that unemployment and/or Medicaid were not predictors of poor weight loss after VBG.[29] This has implications for current Medicaid coverage in Mississippi, which does not reimburse for obesity surgery and may therefore be depriving a significant number of patients of a viable option in weight management.

Patient Satisfaction

The majority (73%) of patients reported satisfaction with surgery at follow-up. Those who were dissatisfied in the primary VBG group had failed to lose as much weight as they had expected while those in the revision group were heavier post-operatively than before. As demonstrated in previous studies,[30] while weight loss did correlate positively with satisfaction, the actual *amount* of weight lost had little bearing on patient opinion of VBG, with many satisfied subjects remaining significantly obese. In fact, two patients who had regained all weight initially lost after the procedure seemed to look back on their temporarily thinner state with nostalgia and affirmed that surgery was worth the experience (see Table 10).

Eighty-one percent of patients who were satisfied with the results of their surgery also felt themselves to be more physically attractive at follow-up. Again *any* weight loss, rather than a specific quantity of weight loss, contributed to improvements in physical self image.[30,31] Two patients, however, expressed some ambivalence on this issue: they were unable to accept their thinner appearance. Two other patients felt more attractive overall, but were

Table 9
Employment Profile of VBG Patients

	Before VBG	After VBG
Unemployed	11	8
Employed	11	14

n=22

Table 10
Patient Satisfaction with VBG

	Primary VBG # patients	Revision to VBG # patients
Yes	14	2
No	4	2
n=22		

dismayed by the excess abdominal skin or "flab" remaining after weight loss. Plastic surgery will correct this, but it is a luxury which few of the morbidly obese can afford.

The vast majority (82%) of patients followed-up indicated acceptance by family and friends as overweight preoperatively, with only a slight increase in acceptance postoperatively (86%). Most patients stated it was their own idea to obtain surgical treatments for obesity, with one individual noting that, "My parents tried to talk me out of it [VBG]."

Discussion/Conclusion

Although it was nearly unanimous among subjects that their VBG was "worth it," from a strictly clinical standpoint this is not so clear. Success as defined by the patient often differs from that defined by the medical profession — and even members of the profession differ. Some define "success" as a percentage of excess weight lost, with values ranging from $\geq 50\%$ [33] to $\geq 40\%$ [24] to $\geq 20\%$.[29] Some choose to look at percent *preoperative* weight lost, with success defined as $\geq$ 25% weight loss[34] and > 15%.[35] Some adhere to weight loss within 40% of ideal as determined by insurance tables.[32] Of course, success could most stringently be defined as weight loss to ideal. But the likelihood of this being achieved for ever 5 years is less than the same individual's chance of being cured of most forms of cancer.[36] Weight loss simply *approaching* the ideal range follows a gradient of progressively decreasing mortality; the actual amount of weight loss one wants to pick as corresponding to a significant decrease in mortality risk is still arbitrary.

Others have attempted to account for response to obesity-related medical problems in addition to actual weight loss.[22] Still others describe physical limitations and psychosocial disabilities as principal problems for the morbidity obese and hinge success of surgery on amelioration of these problems.[30] Rather than choosing a specific cut off value in weight loss a defining success versus failure, perhaps the definition of success needs to be made individually on the basis of the problem for which the procedure was performed, whether the problem was a specific medical disorder or physical and social limitation secondary to morbid obesity.[30]

Van Staden and Gerhardt examine reasons why overweight subjects abandoned weight loss programs.[37] Similar factors may undermine long-term ability to maintain weight loss after VBG. VBG, and, indeed, all bariatric surgery, forces compliance with weight loss objectives, but can ultimately be defeated is subjects fail to make behavioral modifications. Factors leading to inadequate weight loss include disinterest in exercising, acceptance by family and friends as overweight, self-perception as always being overweight and difficulty controlling impulsive food intake. In our study, the majority of patients were accepted by their family and friends as obese. They tended to revert to their preoperative high fat, high sugar diets and to continue their sedentary lifestyles, the immediate rewards of which outweighed the relative deprivation and constraint demanded for long-term weight loss.

Sugerman, et al suggest Roux-Y gastric bypass rather than VBG in patients identified preoperatively as sweet eaters. Snacking upon sweets is limited by a "dumping syndrome".[24] There is some question, however, whether VBG and other gastric partitioning procedures actually promote development of snacking behavior. Sugerman has noted development of maladaptive eating behavior in 10% of patients who had undergone VBG in his series.[24] These patients, who were not sweet eaters prior to surgery, increased intake of candy, ice cream and soft drinks postoperatively as this was better tolerated than beef and potatoes. In this series, 2 subjects specifically mentioned the ease with which "junk food" seemed to "go down." Other have also noted failure of VBG with weight gain in patients who "learn to eat the things that go down easily".[15]

There is the further question of weight loss over time. Over how long a period does weight loss lead to a corresponding decrease in morbidity and mortality? If, as results from this study suggest, the regaining of weight postoperatively is progressive, can VBG be advocated as effective therapy for obesity? Due to the small sample size of our series and the failure to follow-up on a significant number of patients, it is not possible to make a definitive statement regarding ultimate efficacy of VBG in the treatment of obesity. The lack of similar longitudinal studies on a larger scale account for the continued divisiveness among experts regarding the established safety and effectiveness of

VBG in the treatment of resistant cases of obesity.[21]

Physicians are not immune to prejudice against the obese[38,39] and must not summarily judge their obese patients as "hopeless." Bariatric surgery is a well-established option, and VBG is particularly attractive as it is a simple procedure entailing few postoperative complications. As more long-term studies are published, perhaps greater consensus can be reached among the medical profession as to what constitutes successful weight loss, and subsequently whether or not VBG is a truly effective procedure in the treatment of morbid obesity. At least from the patient's standpoint, VBG is "worth it." ❑

P.O. Box 339
Centreville, MS 39631-0339

REFERENCES

1. Sorensen TIA, Price RA, Stunkard AJ, Schulsinger F. Genetics of obesity in adult adoptees and their biological siblings. *BMJ* 1989;298:87-90.
2. Stunkard AJ, Foch TT, Hrubec Z. A twin study of human obesity. *JAMA* 1986;256(1):51-54.
3. Schlundt DG et al. Obesity: a biogenetic or biobehavioral problem. *Intl J Obesity* 1990;14:815-828.
4. Gortmaker SL, Dietz Jr., Cheung LW. Inactivity, diet, and the fattening of America. *JAmDieteticAssoc.* 1990;90(9):1247-1255.
5. Holden WL. Obesity in North America and the Netherlands. *Lancet* 1986;1:100-101.
6. Lewis R. Overblown reports distort obesity risks. *Science* 1981;211:258.
7. Wadden TA, Stunkard AJ. Social and psychological consequences of obesity. *Ann Intern Med* 1985;103:1062-1067.
8. Kral JG, Heymsfield S. Morbid obesity: definitions, epidemiology, and methodological problems. *Gastroenterol Clinics N Am* 1987;16(2):197-205.
9. Garfinkel L. Overweight and mortality. *Cancer* 1986;58(8)supplement:1826-1829.
10. Drenick EJ. Definition and health consequences of morbid obesity. *Surg Clin N AM* 1979;59(6):963-976.
11. Drenick EJ, Gurunanjappa SB, Seltzer F, Johnson DG. Excessive mortality and causes of death in morbidly obese men. *JAMA* 1980;243:443-445.
12. Yale CE. Gastric surgery for morbid obesity. *Arch Surg* 1989;124:941-946.
13. Bernstein RS, VanItallie TB. An overview of therapy for morbid obesity. *Surg Clin N AM* 1979;59(6):985-994.
14. Andersen T. Stokholm KH, Backer OG, Quaade F. Long-term (5-year) results after either horizontal gastroplasty or very-low-calorie diet for morbid obesity. *Intl J Obesity* 1988;12:277-284.
15. Masson EE. Vertical banded gastroplasty for obesity. *Arch Surg* 1982;117:701-706.
16. Burton BT, Foster WR, Hirsch J, VanItallie TB. Health implications of obesity; an NIH consensus development conference. *Intl J Obesity* 1985;9:155-169.
17. Linner JH. Gastric operations: general principles. In: *Surgery for Morbid Obesity*. New York: Springer-Verlag, 1984:55-56.
18. Garrow JS (1981) Assess priorities. In Garrow JS. Treat Obesity Seriously. A Clinical Manual. Edinburgh: Churchill Livingstone, pp 8-17.
19. Masson EE. Evolution of gastric reduction for obesity. *Contemporary Surg* 1982;20:17-24.
20. Willbanks OL. Gastric restrictive procedures: gastroplasty. *Gastroenterol Clinics N AM* 1987;16(2):273-281.
21. Diagnostic and Therapeutic Technology Assessment (DATTA). Gastric restrictive surgery. *JAMA* 1989;261(10):1491-1494.
22. Brolin RE. Results of obesity surgery. *Gastroenterology Clinics of N Am* 1987;16(2): 317-338.
23. Stunkard AJ, Albaum JM. The accuracy of self-reported weights. *Am J Clin Nutr* 1981;34:1593-1599.
24. Sugerman HJ et al. Weight loss with vertical banded gastroplasty and roux-Y gastric bypass for morbid obesity with selective versus random assignment. *Am J Surg* 1989;157:93-102.
25. Makarewicz PA et al. Vertical banded gastroplasty: assessment of efficacy. *Surgery* 1985;98:700-707.
26. MacLean LD, Rhode B, Shizgal HM. Nutrition after vertical banded gastroplasty. *Ann Surg* 1987;206(5):555-563.
27. Mason EE et al. Vertical banded gastroplasty: a seven year review. Unpublished data.
28. Yale CE. Conversion surgery for morbid obesity: complications and long-term weight control. *Surgery* 1989; 106(8):474-480.
29. Yale CE, Weiler SJ. Weight control after vertical banded gastroplasty for morbid obesity. *Am J Surg* 1991;162:13-18.
30. Hawke A, et al. Psychosocial and physical activity changes after gastric restrictive procedures for morbid obesity. *Aust N A J Surg* 1990;60:755-758.
31. Rand CSW, MacGregor AMC. Morbidly obese patient's perceptions of social discrimination before and after surgery for obesity. *South Med J* 1990;83(12):1390-1395.
32. Owen ERTC, Abraham R, Kark AE. Gastroplasty for morbid obesity: technique, complications and results in 60 cases. *Br J Surg* 1989;76(2):131-135.
33. Halverson JD et al. Gastric bypass for morbid obesity: a medical-surgical assessment. *Ann Surg* 1981;194:152-160.
34. Pories WJ et al. The effectiveness of gastric by pass over gastric partition in morbid obesity. *Ann Surg* 1982;196:389-399.
35. Freeman JB, Burchett H. Failure rate with gastric partitioning for morbid obesity. *Am J Surg* 1983;145:113-119.
36. Brownell KD. Understanding and treating the serious, prevalent and refractory disorder. *Consult Clin Psychol* 1982;50:820.
37. Van Staden F, Gerhardt C. Abandoning weight-loss programmes. *SAMJ* 1991;79:554-557.
38. Young LM, Powell B. The effects of obesity on the clinical judgements of health care professionals. *J Health Soc Behav* 1985;26:233-246.
39 Maiman LA et al. Attitudes to-

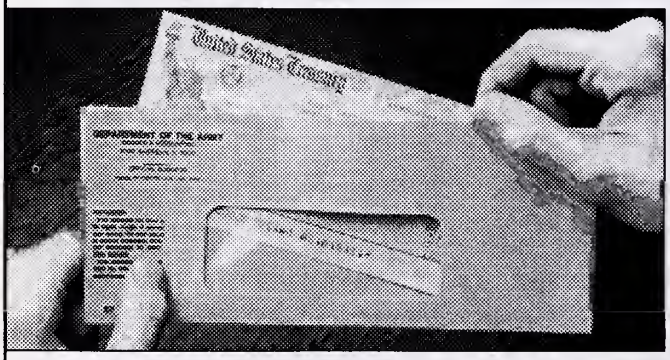
wards obesity and the obese among professionals. *J Am Diet Assoc* 1979;74:331-336.

Dr. Richard J. Field, Jr., and **Dr. Richard J. Field, III** are general surgeons in private practice at The Field Clinic in Centreville, MS. **Sue Y. Parks** is a Senior Medical Student, Tulane University School of Medicine, New Orleans, LA.

RESIDENT ALERT: IF YOU COULD USE OVER $25,000 A YEAR– ANSWER THIS AD.

The U.S. Army's Financial Assistance Program (FAP) will subsidize training in certain specialties totaling over $25,000 a year.

Here's how it breaks down - an annual grant, plus a monthly stipend and reimbursement of approved educational expenses.



You will be part of a unique health care team where you will find many opportunities to continue your education, work at state-of-the-art facilities, and receive outstanding benefits.

So, if you are a resident who could use over $25,000 a year, contact an Army Medical Counselor immediately. 504-522-1872

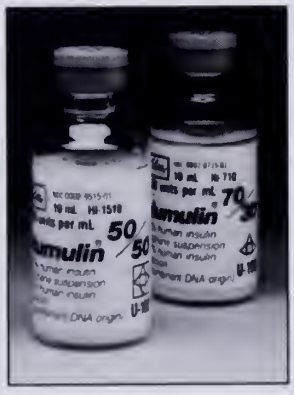
ARMY MEDICINE. BE ALL YOU CAN BE.®



Because One Size Doesn't Fit All...

New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30*, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.



***New* Humulin® 50/50**

50% human insulin isophane suspension
50% human insulin injection (recombinant DNA origin)

The Newest Option in Insulin Therapy

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

*Humulin® 70/30 (70% human insulin isophane suspension, 30% human insulin injection [recombinant DNA origin]).

Lilly

Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

HI-7911-B-249343 © 1992, ELI LILLY AND COMPANY



The President's Page

WILLIAM C. GATES, MD

"Practicin' medicine ain't no fun anymore ...."

Everywhere I've gone in the state and the nation over the past several years I have heard a recurrent theme in conversation with other physicians — that theme is reflected in the title of this piece. In my opinion it has increased with alarming frequency and intensity as a topic of discourse among physicians. It is reflected in fact by the large number of physicians who are retiring early or are altering or modifying their manner of participation in the health care delivery system. I'll bet that you have noticed the recrudescence of this theme yourself and its intensification over the last several years: you may have even uttered the same words in dialogues lamenting the current state of affairs. I have been surprised on occasion to find myself slack-jawed, mule-eyed and slumped, feeling and saying the same thing or a close equivalent.

As a consequence of that realization, I began to search for the factors that seem to generate that feeling, hoping to find some commonality with myself and my colleagues while searching to discover something concrete that we could attack to improve or get rid of those negative emotions.

As I questioned myself and many others about the hassle factors and the definition of "fun" and its antithesis as applied to "practicin' medicine", several observations were made and several truths (as I see them) emerged.

First place of things that bug doctors seems to be loss of physician autonomy and having "them" tell us how to "practice medicine" (length of stay, preadmission, review and approval, second opinions and the like). These activities have fostered the growth and proliferation of several layers of administrative bureaucracy in health care, often without demonstrable positive impact on cost and quality and are certainly a source of every day consternation for most physicians.

In second place (close) is lost income because of "them" and their interference with the doctor-patient relationship (as an aside, I truly hope that we can come up with new terms to replace "doctor-patient relationship" and "organized medicine"). Many of the utilization review and quality review activities of the PRO's and private

(Continued on page 436)

Editorials

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXXIII, NUMBER 12
DECEMBER 1992

MFMC Works For You

After a hiatus of several years, I again have the privilege of serving on the board of directors of the Mississippi Foundation for Medical Care. Since I rejoined the board six months ago, the outstanding work of the Foundation, for physicians and patients in this state, has been refocused for me. The competence and dedication of Fred Parish, Dr. Jim McIlwain, and their staff as well as that of the review physicians, is exemplary and highly professional. The Foundation has served as a much needed buffer between providers and third parties, while helping to assure quality care for patients.

The Foundation was recently granted a new contract for Medicare review by HCFA. The new rules for review of care under this new contract emphasize quality assurance with a strong educational component, and with much less emphasis on the sanction process than has previously been the case. This is good news for physicians and for quality care. Past experience with HCFA may warrant a dose of skepticism, but the intent for positive change based on sound principles of quality measurement seems honest enough and deserves a fair trial.

As the Foundation moves into uncharted territory in the process of implementing the new contract, the support of Mississippi physicians is needed (and deserved) more than ever to help assure a desirable outcome. Our cooperation with the Foundation, when indicated, is the best hope for preserving some degree of physician autonomy with regard to quality of care in these changing times.

George E. Abraham, II, MD
Associated Editor

Are doctors respecting living wills? Is the intent too poorly expressed?

Too often I see vegetative states being kept alive when their living wills clearly state that the intent of the patient under these circumstances, is to be allowed to die with dignity.

We seem to forget that life is finite and that death is inevitable. Keeping terminally ill patients alive is tremendously expensive and results in healthcare dollars being ill spent.

I am eighty-one years of age and like to think I have retained a modicum of mental aptitude. My living will clearly spells out that I want no terminal care that would prolong life. In event of cardiac arrest I want no effort made at resuscitation and in event of stroke or senile dementia I want to be allowed to die.

Terminal illness can exhaust the resources of spouses who might otherwise be reasonably financially independent.

Whether one agrees or disagrees with these thoughts we should all have a living will, clearly stating our desires, properly notarized, and naming an executor who fully understands our wishes and will insist that they be executed.

It is comforting to me that in the absence of a stroke I will not have to wait to die in a nursing home. It is also comforting to know that my executrix, who is not my wife, will insist that my desires by carried out.

W. Moncure Dabney, MD
Editor Emeritus

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

President's Page

(Continued from page 434)

health care management firms smack more of cost reduction ("containment") than they do of quality improvement or the old term "quality assurance". The blatant reductions in reimbursement as a consequence of the RBRVS scheme for physician payment are painfully obvious. [And we were promised by congress that RBRVS would not be used as a budget-reduction tool. It wasn't until Mr. Darman of the White House budget staff and his horde of budget-bleeding leeches saw an opportunity to ratchet down expenditures for physicians that the term "behavioral off-set" adjustments, later called "baseline adjustments" so that it was more palatable to physicians came into being. (We owe that last term to Dr. Wilensky)].

In third place (close) is the awareness of the litigious atmosphere in which all practice these days and the strain that it places on the physician-patient interaction not to mention the additional cost of C.M.A. type defensive medicine to the health care system. It's easy to conjure up the not-too-unrealistic image of vultures hovering over the doctor-patient interaction, watching for any opening to swoop in and devour the unsuspecting, altruistically "tender" physician - spliting the meat up with the whole gang (40-60 split; however, vultures, 60, plaintiffs, 40).

In fourth place (close) seems to be the bemoaning of the tarnished image of the physicians. The collective image seems to be that of the fat, bilious, blood-sucking, money-grubbing, cold-hearted cat in a flashy luxury car wearing Gucci loafers and designer suits with no time for patients during office hours and unavailable after office hours (probably playing golf at the country club) - if you get the picture. *Perception is reality* but often has very little to do with truth.

Well, the more I learned and realized, the more depressed I got — until it became apparent to me that pretty much all of the factors I had identified had to do with the *environment* that we practice in, not *the practice* itself. If you stop and really think about it, practicing medicine is a great deal more fun *and* easier than it was just twenty years ago. We can with relative ease diagnose many things that were considered quite occult in the past. Not only that, but our treatments of many of the diseases that were untreatable in the past are relatively easy and effective. The high technology that is commonly available today in diagnosis and therapy was "Buck Rogers" funny-book material a scant forty years ago. We've come a long way since the days when caring and compassion were the currencies of our practice and essentially all we had to offer. I'm convinced that we must be careful to include caring in our delivery of high-tech health care — it may just be the polish that helps take the tarnish off the image.

The practice of medicine (the doctor-patient relationship) has a life of its own. It stands independent of all environmental factors such as reimbursement, hassle-factors, greedy trial lawyers and government intervention. It's the *joie de vivre* and sense of fulfillment you have that brims your soul when you know you have "done good" for another human being and you know they sense it, too. It's a double-edged sword, however, and cutting in the opposite direction, it is the dismal depth of despair pervading your whole being when you have done all you can do and know that you can do no more. The depth is as deep as the height of the high. The only other way I can think to describe the real core of the practice of medicine is to think of what you could give to a fellow being who is ill in an environment devoid of compensation, tort law, fear of reprisal and accountability — perhaps a missionary setting would be a suitable analogy. If you can imaging yourself giving yourself in that environment and the sense of fulfillment and satisfaction being the same, then you know what I'm trying so hard to say. Most other professions are not blessed with access to this quality. I suspect the majority of lay people would not truly understand what I'm saying.

As you have heard me say before, practicing medicine is more fun that it has ever been, contrary to what you might hear from some quadrants. The environment that we practice in is where the problems are. It would serve us well to keep the environment from marring the truth and beauty of the practice. Let's fight the peripheral hassle factors in a different arena and avoid mixing the "practice of medicine" in the muddlement...

I hope my note finds you and yours doing well... Merry Christmas!

Best Regards,
Bill

"Current Opinions"

of the Council on Ethical and Judicial Affairs of the American Medical Association

OPINIONS ON PROFESSIONAL RIGHTS AND RESPONSIBLITIES

ACCREDITATION

Physicians who engage in activities that involve the accreditation, approval or certification of institutions, facilities and programs that provide patient care or medical education or certify the attainment of specialized professional competence have the ethical responsibility to apply standards that are relevant, fair, reasonable and nondiscriminatory. The accreditation of institutions and facilities that provide patient care should be based upon standards that focus upon the quality of patient care achieved. Standards used in the accreditation of patient care and medical education, or the certification of specialized professional attainment should not be adopted or used as a means of economic regulation.

AGREEMENTS RESTRICTING THE PRACTICE OF MEDICINE.

The Council on Ethical and Judicial Affairs discourages any agreement between physicians which restrict the right of a physician to practice medicine for a specific period of time or in a specified area upon termination of employment or a partnership or a corporate agreement. Such restrictive agreements are not in the public interest. ❑



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

A singer. A board-certified family practitioner. Soft-spoken for a New Yorker. Ron Richmond knows...

It's a great way to practice medicine

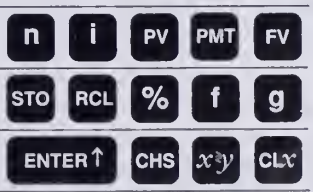
CompHealth
LOCUM TENENS

1-800-453-3030
Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

Do your Retirement Plan Investments need a *Shot in the Arm?...*

Consider Medley & Company.
We access top-notch money managers through no-load mutual funds - using a proven asset allocation model - so that you can have a *healthy* retirement plan.

Call for a free brochure.



MEDLEY & COMPANY
Investment Counsel

1640 Lelia Drive, Suite 230
Jackson, MS 39216
601 / 982-4123 • 1/800 / 844-4123

NATIONAL HOME CARE WEEK
NOVEMBER 29-DECEMBER 5, 1992

THE PROVIDER AND ASSOCIATE MEMBERSHIP OF THE MS ASSOCIATION FOR HOME CARE WISHES TO EXPRESS APPRECIATION FOR ALL PHYSICIANS WHO PROVIDE HOME CARE REFERRALS AND MEDICAL MANAGEMENT OF THE HOME HEALTH PATIENT CARE PLAN. THROUGH YOUR EFFORTS, APPROXIMATELY 61,000 MISSISSIPPI PATIENTS RECEIVE HEALTH CARE AT HOME.

ALEXANDER'S HOME HEALTH

CAPITOL HOME HEALTH

CENTRAL MS HEALTH CARE AT HOME

COMFORTCARE HOME HEALTH

DELTA COMMUNITY HOME HEALTH

FORREST GENERAL HOME CARE

GILBERT'S NORTH MS HOME HEALTH

HOME HEALTH CARE OF MS

HOME HEALTH OF MS [RUSH HOSPITAL]

KARE-IN-HOME HEALTH AGENCY

LAIRD HOSPITAL HOME HEALTH AGENCY

MAGNOLIA HEALTH SERVICES

MEDGAR EVERS HOME HEALTH AGENCY

MID-DELTA HOME HEALTH

MID-SOUTH COMPREHENSIVE HOME HEALTH

MS METHODIST REHAB CENTER HOME HEALTH DEPARTMENT

MS REGIONAL HOME HEALTH CARE.

NORTH MS MEDICAL CENTER HOME HEALTH

PROFESSIONAL HOME HEALTH

QUALITY HOME HEALTH CARE

SERVE-U HOME HEALTH

SOUTH MS HOME HEALTH

STA-HOME HEALTH AGENCY

SUPERIOR HOME HEALTH

TRI-COUNTY HOME HEALTH CARE

ALLEN'S PRIVATE DUTY NURSING.

BFI MEDICAL WASTE SYSTEMS

CAREMARK

CROWELL, THAMES & HART, LTD.

GULF SOUTH MEDICAL SUPPLY

HEALTH CARE ENTERPRISES

HEALTH CARE MGT CONSULTANTS

HORNE CPA GROUP

HOSPITALS AFTERCARE OF JACKSON

IV THERAPY AT HOME

KIRKLAND, BARFIELD & MOORE, ATTORNEYS

MASTERS MEDICAL SERVICES

PHARMATHERA

PROVIDER SOLUTIONS

SYNCOR HOME CARE SERVICES

UNITED MEDICAL

MAHC

MISSISSIPPI ASSOCIATION for HOME CARE

Medical Organization

Services Held For Dr. Carl G. Evers

Dr. Carl G. Evers of Jackson, died at the University of Mississippi Medical Center on Thursday, November 19, of injuries sustained in a bicycle accident on March 8.

Dr. Evers, 58, was professor of pathology and associate dean for academic affairs in the School of Medicine and medical director of the cytotechnology program in the School of Health Related Professions at the University of Mississippi Medical Center. Memorial services were held at St. Philips Episcopal Church in Jackson on Sunday, November 22.

"Dr. Evers was a superb physician, an exceptional teacher and a nationally known medical educator," said Dr. Norman C. Nelson, vice chancellor for health affairs and dean of the School of Medicine.

"As an assistant dean and then associate dean of the School of Medicine since 1973, he worked closely with every one of our classes — giving students counsel on course work, advice on specialty selection and being the kind of faculty friend upon whom they could always depend," Dr. Nelson said. He was



a major influence in our students' professional education and through them will have a continuing positive impact on the practice of medicine in our state for many years to come".

A graduate of Mankato State College in Minnesota, Dr. Evers earned the M.D. in 1959 at the University of Minnesota and took his residency in anatomic and experimental pathology at UMC. He joined the School of Medicine Faculty in 1964 as an instructor in pathology, was promoted to assistant professor in 1966, associate professor in 1968 and professor in 1975. He received a number of awards for teaching excellence in the School of Medicine including the "Best Preclinical Faculty Award" for the years 1965-1970 and the "Professor of the Year Award" in 1973.

Dr. Evers served the Mississippi State Medical Association in many capacities including president, member of the Board of Trustees, speaker of the House of Delegates, and member and chairman of the Council on Medical Education. At the time of his death, he was on the board of the Mississippi Physicians Insurance Company. He had served as a Mississippi delegate to the American Medical Association since 1986 and had been a member of the AMA's Section on Medical Schools since 1972. He was elected to the AMA's Council on Medical Education in 1991, the first Mississippian to serve.

He has served on the executive, membership and pathology committees of the Gynecological Oncology Group, a national cooperative group funded by the National Cancer Institute to evaluate new treatments in gynecologic cancer. Active in the Association of American Medical Colleges (AAMC), Dr. Evers had served as secretary, vice chairman and chairman of the AAMC Southern Regional Group on Student Affairs and on the national group's steering committee. He served as an

accreditation site visitor for the American Society of Cytology and for the AMA's Committee on Allied Health Education and Accreditation. He was a member of Alpha Omega Alpha, national medical honorary, and had served as president of the Mississippi Association of Pathology.

His other professional memberships included the College of American Pathologists, American Society of Clinical Pathologists, American Society of Cytology, the United States and Canadian Academy of pathology, American Association for Cancer Education, Sigma Xi, scientific honorary. He was a member of Ascension Lutheran Church where he was vice president of the church council.

Survivors include his wife, Jan, and three children: Karen, Julie and Gus; brothers Ewald and Donald Evers of Lake Benton, Minnesota and Norman Evers of Aurora, South Dakota, a sister, Alice Kern of Chester, South Dakota, and several nieces and nephews.

Honorary pallbearers were Dr. Lon F. Alexander, Dr. Norman C. Nelson, the faculty of the University of Mississippi Medical Center, physician colleagues and staff of the Mississippi State Medical Association, Dr. Roger B. Arhelger of San Antonio, Texas, and Walton T. Woods, Jr., of Jackson.

In lieu of flowers the family asks that memorials be sent to the Carl G. Evers Scholarship Fund in care of the Mississippi State Medical Association, Ascension Lutheran Church of Jackson, St. Philips Episcopal Church of Jackson or the American Cancer Society, Mississippi division. ❑



Dr. Lee Giffin of Vicksburg, left, recipient of the Mississippi Public Health Nursing Citizenship Award is pictured with Ms. Salena Greenlee, RN, coordinating nurse, Warren County Health Department, right.

Dr. Lee Giffin Receives State Honor

The Mississippi Public Health Nursing Citizenship Award was presented to Dr. Lee Giffin during the Nursing Division Awards Luncheon held in conjunction with the Mississippi State Department of Health's State Convention in Biloxi. The Award, established in 1991, is presented annually to a Mississippi resident who is not employed by the State Department of Health but who has shown outstanding support to the profession of Public Health Nursing in addition to making an outstanding contribution to his/her community.

Dr. Giffin played an important role in making the recently opened "807 Clinic" a reality for Warren County citizens. The clinic provides free, confidential testing and patient education in addition to early medical treatment for Warren County HIV/AIDS patients. Dr. Giffin, working with Salena Greenlee, RN and co-ordinating nurse at the Warren County Health Department, spearheaded the recruitment of over 15 local physicians who have agreed to donate up to eight hours per month of their time to treat patients at the "807 Clinic". The clinic, a result of city, county, state and federal governments working together with private physicians, has been proclaimed a model community initiative by State Health Department officials.

In nominating Dr. Giffin, Ms. Greenlee acknowledged "without his efforts, there would be no '807'; a true role model for all private and public health workers, his efforts go beyond the normal obligation to his profession and community".

Dr. Giffin, a native of Louisville, is a family physician in private practice at The Family Medicine Clinic in Vicksburg. A gradu-

ate of Mississippi State University, he received his MD from The University of Mississippi School of Medicine and completed a Residency in Family Medicine at the University of Mississippi Medical Center.

He serves as a Clinical Instructor in Family Medicine through UMC and as a Medical Student Preceptor through the Department of Family Medicine, UMC. Dr. Giffin is also serving as chief of staff at the Vicksburg Medical Center.

Board Certified by The American Board of Family Practice, Dr. Giffin holds memberships with The American Academy of Family Physicians, The West Mississippi Medical Society, MSMA, AMA, MFMC, The American Diabetic Association and is on the Board of Directors for the Warren County Home Health Services.

Dr. Giffin is married to the former Jane Posey of Philadelphia, Mississippi and they have three daughters, Mary Claire, Melissa and Kayline. ◻



SPECIALIZE IN AIR FORCE MEDICINE.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle , quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. Find out how to qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

Central Medical Society Auxiliary Adopts Blake Clinic as Special Project

Mississippi First Lady Pat Fordice and Jackson Mayor Kane Ditto were two of the more than 150 people who gathered in Jackson Thursday, October 29, at an Open House to show their support for the Blake Clinic for Children.

Blake Clinic is the main referral center for a statewide network of clinics. The clinics serve about 6,000 children each year as a part of the Mississippi State Department of Health's Children's Medical Program. Blake Clinic staff provide medical assistance to children with physical handicaps and special health care needs. The clinic has one full time staff physician. Some resident physicians and medical students at UMC also serve in the clinic. Many private physicians offer their services to staff the various specialty clinics, serve as consultants, or accept referrals to their offices or medical centers for evaluation and surgical procedures.

The Central Medical Society Auxiliary sponsored the Open House to showcase the recent "face-lift" they've given the clinic, CMA — an organization of spouses of practicing, retired, and deceased physicians of six central counties — with the support and encouragement of Dr. Alton B. Cobb, state health officer, has chosen Blake Clinic as their service project for the year.

Central Medical Auxiliary members have solicited donations of furniture, carpet, artwork, and landscaping from local businesses and individuals to improve the Clinic's physical appearance. They've also scheduled several fund-raising projects. These projects include: (1) a gardening fund raiser at the Agricultural and Forestry Museum - including two round trip American Airlines Tickets to London; (2) a Doctor's Day benefit and (3) publishing a coloring book with proceeds donated to the Blake Clinic.

Children's Medical Program receives federal and state funding as well as private donations and provides assistance to families with limited resources. While CMP accepts Medicaid and private insurance as payment, the care for these children is extensive and long and the costs are enormous.

Children's Medical Program provides many services to children, including surgical correction for congenital heart defects, cleft palate surgery, and correction of certain eye defects. The staff also works with children who have orthopaedic conditions, genitourinary defects, sickle cell, cystic fibrosis, hemophilia, gastrointestinal defects, congenital defects of the nervous system, and many other conditions.

The CMP is a wonderful example of what the public and



Many special guests, patients, staff members, and Central Medical Society Auxiliary members participated in the Blake Clinic Open House.

private sectors working together can accomplish. CMA President, Jane Ladner said, "The Central Medical Auxiliary is proud to be apart of the effort."

For more information about Blake Clinic or the Children's Medical Program, call CMP of Jackson at 987-3965. For more information about the Central Medical Auxiliary or their fundrasing activities, write, PO Box 12731, Jackson, MS 39236-2731.



Central Medical Auxiliary members involved in the Blake Clinic project are: back row from left, Martha Smith, project chairman, Jane Ladner, CMA president, Carole Sudduth, CMA president-elect, front row from left, Shari Lackey, open house co-chairman, Lynn Green Root, author of coloring book and Marsha Cannon, CMA vice-president and open house co-chairman.

Below, left, Clinic Director Dr. Elizabeth Keeling is shown with Mary Frances Blake, widow of Dr. Tom Blake. A portrait of Dr. Blake, at right, hangs in the Clinic which bears his name.







Also participating in the Open House were, Sam Valentine, left, Director of CMP, and at far right, Mary Moore, Branch Director of CMP. They are pictured with Jane Ladner, Mary Frances Blake, Dr. Keeling and Martha Smith.

PROBLEM:

NON-COMPLIANCE

ANSWER:

AUTOMATED MEDICATION DISPENSER



Locks
Alarms
Dispenses
Battery Backup
Easy To Program
Insulin Reminder
Medication Messages

Optional Visual Alarm For
The Hearing Impaired
Remote Monitoring Available

The Bottom Line....
Improved Compliance
Reduced Stress and Worry
Increased Patient Independence
$495.00

Dispenses
Medications
Up to Four
Times Daily

Removable
Medication Tray
Holds One Week Supply

Call:
Jim Parkin
Care Medical
Madison, MS
853-2877
1-800-748-8768

CompuMed AUTOMATED MEDICATION DISPENSER

New Members

Banquer, Kirk J., Hattiesburg. Born February 5, 1957 in New Orleans, LA; MD, Louisiana State University School of Medicine, New Orleans, LA, 1983; interned and surgery residency, University Medical Center, Jackson, MS, 1983-88; elected by South Mississippi Medical Society.

Bock, Hans-Georg O., Jackson. Born Mahlum, Germany, May 5, 1946; MD, Vanderbilt University School of Medicine, Nashville, TN, 1977; pediatric residency, Baylor College of Medicine, Houston, TX 6/77-12/79; fellowship pediatric genetics, Same, 1/80-2/83; elected by Central Medical Society.

Davis, Kenneth M., Tupelo. Born New Orleans, LA, January 6, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1983; interned and medicine residency, Harvard Medical School, Boston, MA, 1983-87; geriatric medicine fellowship, Same 1987-90; Masters of Science & Health Policy and Management and fellowship in Clinical Effectiveness, Same; elected by Northeast Mississippi Medical Society.

Ferguson, Bailey Joe, Jackson. Born Randolph, MS, July 13, 1949; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; diagnostic radiology residency, Same, 1987-91; elected by Central Medical Society.

Haley, Charles T., Grenada. Born Clarksdale, MS, January 19, 1950; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; ob-gyn residency, Charity Hospital of New Orleans, LA, 1987-91; elected





by North Central Medical Society.

Rhodes, Philip G., Jackson. Born Wichita, KS, June 6, 1945; MD, University of Kansas School of Medicine, Lawrence-Kansas City, KS, 1970; pediatric residency, Children's Mercy Hospital, Kansas City, KS, 1970-72; neonatology fellowship, Same, 1972-74; elected by Central Medical Society.

Richardson, Toni B., Meridian. Born Jackson, MS, October 1, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; Ophthalmology internship & residency, UMC, Jackson, MS, 1988-92; elected by East Mississippi Medical Society.

Sams, John Elliot P., Columbus. Born Columbus, MS, March 10, 1959; DO, University of New England College of Osteopathic Medicine, Biddeford, MA, 1990; interned one year Lutheran Medical Center, Brooklyn, NY; family medicine residency, University of South Alabama, Mobile, AL, 1991-92; Elected by Prairie Medical Society.

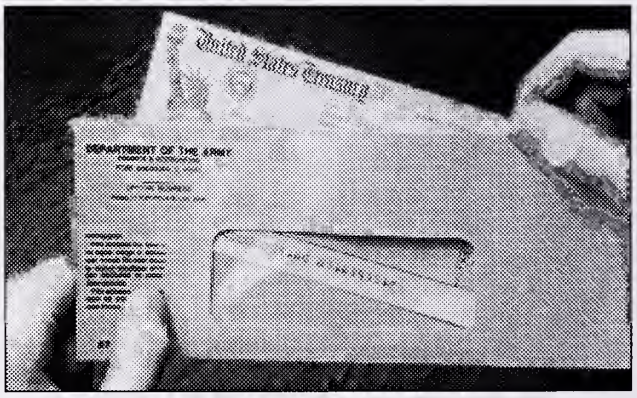
Schwartz, Robin H., McComb. Born McComb, MS, December 14, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned and anesthesiology residency, University of South Alabama, Mobile, AL, 1988-92; elected by South Central Medical Society.

Thomae, Dickinson, Cary. Born Chattanooga, TN, November 6, 1929; MD, University of Mississippi School of Medicine, Jackson, MS, 1955; interned one year Charity Hospital New Orleans, LA; elected by Delta Medical Society.

Zimmerman, Rena B., Meridian. Born Cleveland, OH, September 7, 1957; MD, Northeastern Ohio University College of Medicine, Rootstown, OH, 1983; interned and one year of radiology residency, Same, 1983-85; radiation oncology residency, University Hospitals of Cleveland, OH, 1985-87; elected by East Mississippi Medical Society. ❑

ANESTHESIOLOGISTS AND SURGEONS: COULD YOU USE AN EXTRA $9,000?

If you're a resident in anesthesiology or surgery, the Army Reserve will pay you a yearly stipend which could total in excess of $9,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor. Just call collect 205-930-9727

ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.®

Personals

Bryan Barksdale of Jackson received the 1992 Silver Distinguished Service Award at The American Heart Association Mississippi Affiliate's 1992 annual meeting. He is also the Mississippi AHA's 1991-92 affiliate president.

Sandra F. Burford of Vicksburg was a speaker at the recent Mississippi Learning Disabilities Conference held in Jackson. Her topic was *Evaluation of Children with Attention Deficit Disorder.*

C. Ron Cannon of Jackson presented an instruction course of Nicotene Addiction - Head & Neck Perspective in Washington, D.C. at the American Academy of Otolaryngology - Head & Neck Surgery annual meeting. He is also serving as current president of the MS EENT Society and represented the MS Society and the Mississippi - Louisiana O&O Society at the Board of Governors annual meeting held in Washington.

Alton B. Cobb of Jackson was awarded the Claud L. Batson Award for Meritous Service at a symposium of the Mississippi Chapter of the American Academy of Pediatrics and Claud L. Batson Lecture held recently.

Dewitt Grey Crawford of Louisville has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Robert B. Daggett, has associated with Meridian Medical Associates, P.A. in the practice of Rheumatology-Adult & Pediatric, 2014 15th Street, Second Floor, Meridian, MS.

Suman K. Das of Jackson has been appointed to a three-year term on the editorial board of the *Southern Medical Journal.* He will also chair the meeting of the Section on Plastic and Reconstructive Surgery during the Southern Medical Association's 86th Annual Meeting held in San Antonio, TX.

Deborah J. Downing has associated with Rush Medical Group, P.A., Meridian, in the Family Medicine Department.

Arnold E. Feldman of Natchez has been elected chief of staff of Jefferson Davis Memorial Hospital.

James M. Fuller, Jr., of Jackson is currently serving as AMA-MSS Chapter, president-elect and was appointed to the MSS Legislative Awareness Committee.

Thomas H. Gandy of Natchez was presented the Natchezian Award by the Natchez Chamber of Commerce for his contributions to the medical community and as a volunteer in civic affairs.

Hal. T. Liddell, and Nathan P. Shappley announce the opening of The Urology Center's Office at 1020 Adams St., Laurel.

William D. Logan, Jr of Carthage announces the opening of the Varicose Vein Clinic, 305 Ellis Street, Carthage.

Anna Lou of Jackson has been named chief of pediatric rehabilitation services at MMRC.

George McGee of Hattiesburg recently presented a scientific paper entitled *Laparoscopic Repair of Colonoscopic Perforation* for the XIVth Biennial Congress of the International Society of University Colon and Rectal Surgeons, held in Crete, Greece. The paper was authored by Dr. McGee and **John Bagnato**, also of Hattiesburg in conjunction with two colorectal surgeons from Ochsner Clinic.

Patrick G. McLain of Jackson announces the relocation of his office for the treatment for alcohol, drugs, and eating disorders to Seven Lakeland Circle, Suite 300, Jackson.

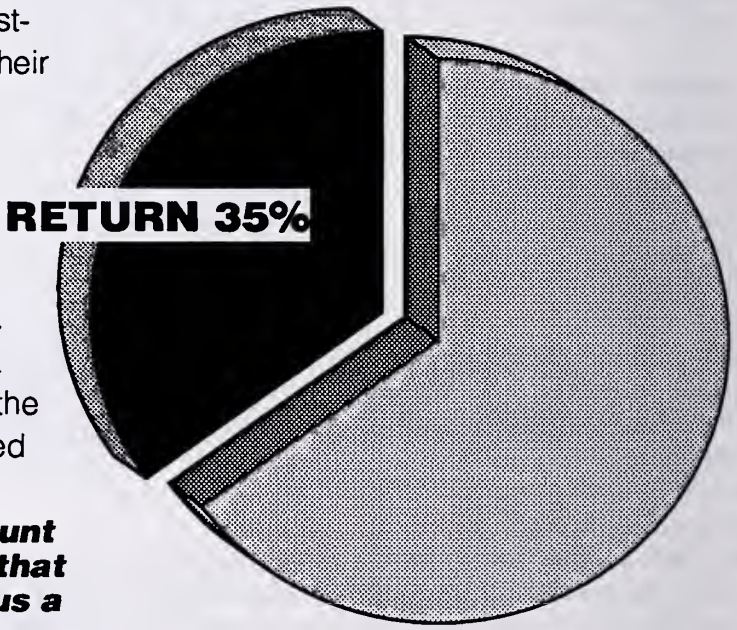
In 1991 our retirement funds earned an average 35% return on investments.*

Employer Plus offers our clients a family of select mutual funds, from one of the nation's leading investment banking firms, to use for their retirement plan investment.

Recent figures for the year 1991, show the ten mutual funds that we most recommended for our clients, averaged a **35%** overall return. One of the ten produced over a **56%** return. the highest, while the lowest return of the ten produced just under a **20%** return.*

If your retirement account is not producing a return that you are happy with, give us a call.

We can help.



Employer Plus, Inc.™

No one administers payroll and employee benefits better!

4537 Office Park Drive • P.O. Box 16283
Jackson, MS 39236-6283 • (601) 366-7293
Toll Free: 1-800-844-0093

**Past performance is no guarantee of future returns.*

© 1992 Employer Plus. All rights reserved.

Alfred E. McNair Jr., of Pascagoula has been appointed medical director for Unicare Home Health of Mississippi, Inc., in Jackson County.

William Meyer of McComb is serving as chief of staff at Southwest Mississippi Regional Medical Center.

Michael A. Reddix, of Jackson has associated with **Carl M. Reddix** and **Natalie Brookins-Reddix** in the practice of internal medicine, 1815 Hospital Drive, Suite 222, Jackson.

F. Clark Sauls of Hattiesburg recently became one of the 880 surgeons nationally to receive certification in critical care as an intensivist.

Robert L. Saulters, of Jackson has associated with The Medical Clinic, P.A. for the practice of internal medicine, 746 Manship St., Jackson.

Merrill J. Shidler has associated with **Joe Stanley Pulliam** of the Family Medical Center, for the practice of family medicine, 1467 Hwy. 1 South, Greenville.

Joseph D. Siefker, of Meridian was recently named a Fellow of the American Academy of Otolaryngic Allergy.

Tommy Simpson of Ripley was recently honored with the 1992 Alumnus of the Year Award, presented by the Northwest Mississippi Community College Alumni Association.

Douglas F. Thomas, of Hattiesburg was elected president of the Mississippi Society of Internal Medicine.

Indira Kota Veerisetty and **Wesley D. Granger** of Ridgeland announce the relocation of their offices to: Cates Plaza Clinic, 12 Professional Parkway, Ridgeland, MS.

Eric J. Wyble of Jackson has been acccpted into The American Association for Hand Surgery. ◻

Physicians' Recognition Award

Two MSMA members were named recipients of the AMA Physicians' Recognition Award in October 1992. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by medical society.

CENTRAL MEDICAL SOCIETY

Ralph Hunter Didlake, MD

Wilford Joel Patterson, MD

Send Items for the
Personals Column
to the Editor,
Journal MSMA
PO Box 5229,
Jackson, MS 39296-5229

The Only Professional Liability Company *Of* Mississippi Physicians, *By* Mississippi Physicians, And *For* Mississippi Physicians.



Medical Assurance Company has proven time and again the benefits of affiliation with a company dedicated to Mississippi physicians. Doctors don't want decisions regarding their practice made by people they have never met with offices thousands of miles away.

When actuarial consultants advised MACM that it might be necessary to raise premiums for pediatricians due to claims losses, the Company spearheaded a mandatory statewide Risk Management Program to address the problem.

By working with us, they were able to reduce losses among pediatricians, thereby avoiding rate increases which would have had a negative impact on health care throughout the State.

MACM insures more Mississippi physicians than any other company for good reason -- they *are* Mississippi physicians. Who could know our needs better?

Dr. Elizabeth Keeling is a Board Certified Pediatrician practicing in Jackson, Mississippi.

MEDICAL ASSURANCE COMPANY OF MISSISSIPPI
1-800-325-4172 or
601/353-2000 in Jackson
735 Riverside Drive ■ Suite 307
Jackson, MS 39202

Several Reasons Why

MPIC's
"Worker's Compensation Program"
Is A **Great** Value

✔ 1. Structured for Physician's offices	Savings
✔ 2. Established by Your Association	Up To
✔ 3. Savings over what you currently are paying	~~15%~~
✔ 4. Responsive to your needs	30 %
✔ 5. Prompt Service	

For an immediate response to your questions about the Mississippi Physicians Insurance Company unique insurance opportunity and other insurance programs to meet your needs call:

Evans/Giordano, Inc.
(601) 957-5100
(800) 748-9713

Sponsored by the Mississippi State Medical Association

INDEX
VOLUME XXXIII

January - December 1992

SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "A," Abstract; "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR" Book Review, "ME," Medical Ethics; "AP," Auxiliary Page; "C," Comments; "S," Special Article; the asterisk (*) indicates and original article in the Journal, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M," respectively. Matter pertaining to MSMA is indexed under "Mississippi State Medical Association."

A

Acute Urinary Obstruction
acute urniary retention due to a free-standing broad ligament Leiomyoma [Rivlin et al] *355
AMA
AMA physicians recognition award
Arora, Rajinder K., 30
Bass, Charles, P., 308
Bass, William L., 238
Blake, Thomas Henry, 74
Blevins, Phillip Kay, 196
Boggan, Austin P., 413
Bosco, Julius A., 308
Brock, Ralph L., 350
Burnham, Van Robinson, 380
Burns, Janis C. Edmonds, 196
Burrow, William Hollis, 30
Butler, Gloria Jean, 238
Carter, Robert F., 115
Causey, Jack Quin, 267
Cirilli, Michael Joseph, 267
Clippinger, David L., 350
Crawford, Dewitt Gray, 380
Creekmore, Samual J., Jr., 156
Day, Larry Hale, 308
Defore, W. Wilson, 267
Didlake, Ralph Hunter, 449
Ederington, John B., 238
Evans, Owen Beverly, 115
Gandour, Michael John, 74
Gore, Edward Kirkham, 308
Grenfeld, Raymond F., 238
Hamblin, Orby Lynn, 267
Harper, John Richard, 350
Hill, J. Edward, 350
Holladay, Walter R., 413
Hotchkiss, Robert L, 380
Ingram, Fred H., 308
Irby, Henry Edward, 380
Jackson, William Gilbert, 380
James, John Hassell, 380
Johnson, Cleveland Eric, 74
Kitchings, Ben Judson, 380
Krooss, William Frederick, 156
Krueger, Ronald P., 308
McClain, Eldon Duane, 238
McCloskey, John J., 74
McIlwain, James S., 156
Middleton, Robert Hiram, 350
Moore, Paul Harold, 350
Pandey, Shanti, 196
Parker, Waylon Morris, 115
Patterson, Wilford Joel, 449
Preau, William Joseph, 380
Pressler, James W., 350
Prosser, Harmon Sidney, 196
Reid, Shelby C., 156
Richardson, David D., 238
Robbins, James Steele, 267
Runnels, G. O., 308
Shrock, Wirt F., 196
Smith, Robert, 156
Stephens, David B. 308
Stroud, Catherine H., 156
Talkington, T. W., 308
Taylor, Jessie Roma, 350
Velasco, Diego, 74
Wadsworth, Henry W., 308
Welch, Carl Chapman, 380
Westbrook, Terry Earl, 380
Wheatley, Mary B., 413
Wilder, S. Jobe, Jr., 196
Williams, Charles Hartwell, 156
Anterior Cruciate Ligament
relationship of anterior cruciate ligament injury to notch width index (a roentgenographic study) [Barrett, Rose and Reid] *279
Appendicitis
laparoscopy for the management of appendicitis [Bagnato]*249
Auxiliary
auxiliary holds media/public relations workshop, 25-N
representing Mississippi in the AMA Auxiliary House of Delegates, 295-N

C

Cancer
adjuvant therapy in primary breast cancer: defining the role of systemic therapy and radiotherapy [Salloum] *5
evaluation of mammographic calcification [Flowers and Launey] *319
evaluation of mammographic stellate lesions [Flowers and Powers] *359
Cardiac Pacing
why not simple ventricular pacing? The hemodynamics of cardiac pacing for noncardiologists [Fyke] * 385
Chemical Dependence
understanding chemical dependence [Milhorn] *123
Cholesterol
a cholesterol reduction demonstration project: results from a challenge between two cities [Muscat et al] *87

D

Deaths
Blake, Thomas H., 303
Campbell, W. Richard, 234
Evers, Carl G., 439-N
Ford, John M., 72
Garrison, Harvey F., 234
Mahalak, Lawrence W., Jr., 234
Martin, Charles H., 234
Moore, Ben Junior, 113
Shaw, Thomas R., 303
Tatum, A. T., 303

E

Ear
bacteriology of middle ear effusions [Cannon, Clay and Wilson] *1

F

Family Practice
graduate follow-up in the University of Mississippi Family Practice Residency Program [Forbes and Walley] *171

G

vertical banded gastroplasty: is obesity worth it? [Field et al] *423

H

Health Care
behavior modification [Abraham] 329-E
"doctor, I've read ..." [Johnston] 179-E
ethics and economics [Abraham] 97-E

Health Access Mississippi, 11-S
primary care physicians in Mississippi: implications for rural health care [Boyd and Bross] *165
Mississippi Comprehensive Health Insurance Risk Pool, 253-S
"the good ole days" [Waites] 20-PP
the best medicine sometimes can't be bought [Johnston] 97-E

L

Laparoscopy
laparoscopy for the management of appendicitis [Bagnato] * 249
Laser Applications
laser applications in the lower genital tract [Fox et al] *203
ophthalmic laser surgery; therapeutic implications for the primary physician [Cotten] *131
Leiomyoma
acute urinary retention due to a free-standing broad ligament leiomyoma [Rivlin et al] *355
Letters
to the Editors, [Hopkins] 54-L; [Henderson] 55-L; [South] 182-L; [King] 257-L; [Gough] 288-L; [Smith] 330-L
to MSMA, [Evers] 218-L; [Jenkins] 397-L

M

Magnetic Resonance Imaging
acute urinary retention due to a free-standing broad ligament leiomyoma [Rivlin et al] *355
Managed Care
managed care, or manage not to care [Waites] 140-L
Medicaid
Medicaid income can be tax-deferred, 285-S
Medicare
AMA addresses Medicare reform issues, 50-S
Medicare part B reviews, 138-S
Medical Ethics
current opinions on practice matters, 57-ME; 101-ME; 331-ME; 367-ME; 399-ME;
current opinions on social policy issues, 259-ME; 289-ME;
medical ethics and medical technology, [Abraham] 217-E
pondering professionalism - profit and piracy or priesthood and philanthropy? [Gates] 256-P
report of the AMA Council on Ethical and Judicial Affairs: reporting impaired, incompetent, or unethical colleagues, 176-ME
Medical Licensure Board
Mississippi State Board of Medical Licensure Annual Report July 1, 1990 through June 30, 1991 [Morgan] 323-S
Medical Organization
address of the president [Waites] 213-S
Medical Organization News
ACOG elects Dr. Hollis president, 229-N
AMA 141st Annual Session, 292-N
CMA Supports Discovery Clinic, 336-N
Doctor of the Day for the 1992 legislative session, 65-N
Dr. C. G. Sutherland retires as MACM medical director, 107-N
Dr. Campbell honored by St. Dominic's, 295-N
Dr. Cobb receives Public Health Association Award of Excellence, 369-N
Dr. Gunn elected president of Medical Alumni chapter, 105-N
Dr. Lee Giffin receives state honor, 440-N
Dr. Segars honored for his efforts, 370-N
Drs. Ellis and Nina Moffit honored by Caduceus Club of Mississippi, 335-N
five delegates receive membership jackets, 294-N
Governor Fordice speakes to Jones County Medical Dental Independent Practice Association, 260-N
local doctor/artist gets special recognition, 371-N
Parameters of Care their future for medicine, 148-N
Pontotoc's Dr. John Patterson named family physician of the year, 401-N
Simmons arboretum embarks on five-year plan to promote nature, 401-N
the inauguration - and thoughts it provoked [Gates] 178-PP
UMC Langford professorship in medicine, 104-L
Vicksburg AIDS Clinic could be model for U.S. small towns, 336-N
"Who killed JFK" ... is lectureship topic, 229-N
Woodrell named director of University Hospitals and Clinics, 105-N
Medical Practice
a prescription for the physician [Waites] 96-PP
"contact your doctor for a prescription" [Johnston] 287-E
"he went off and made a doctor..." [Gates] 216-PP
media managed politics and medical care [Johnston] 395-E
President of the Medical Society Syndrome "PMS-S" [Gates] 328-PP
resolve to be involved [Lockey] 21-E
Sovereign Immunity [Gates] 394-PP
sports page medicine [Lockey] 363-E
T. I. A. and F. F. H. (transient ignorance & apathy and free-floating hostility) [Gates] 362-PP
the eagle flies on the first [Johnston] 53-E
"the man with an eagle in his breast..." [Gates] 286-PP
wild dogs and wildebeest [Waites] 52-PP
Members, New
Bailey, Robert E., 113
Banquer, Kirk J., 445
Barnes, Gary T., 407
Beeman, S. Kenn, 342
Blaylock, Russell L., 301
Bock, Hans-Georg O., 445
Braden, Michael R., Sr., 342
Brandon, Steven C., 407
Brown, Brett O., 407
Burroughs, Judy F., 342
Campbell, Chris, J., 232
Cannella, Dominic Michael, 71
Cheatham, David H., 71
Cole, Craig A., 407
Daggett, Robert B., 407
Davis, Kenneth M., 445
Dayton, Harry E., 71
Donahoe, Edgar N., Jr., 301
Doyle, Donald E., 408
Duggan, Frederick T., 342
Dunsford, Harold A., 301
Durfey, John J., 232
Eggert, Roger A., 301
Elmore, Gary S., 301
Ferguson, Bailey Joe, 445
Ferguson, J. Scott, 342
Fratkin, Jonathan D., 301
Fredericks, Ruth K., 301
Fullenwider, John P. 232
Geissler, William B., 232
Gelder, Maurice D., 301
Gillespie, J. Barry, 342
Goodman, Barbara B., 408
Gorton, Alice M., 342
Grafton, Thomas W., 342
Haley, Charles T., 445
Haltom, J. Mack, III, 301
Havens, Michael R., 342
Herrington, Ronald G., 301
Hill, David R., 71
Hitt, Kevin L, 301
Holland, John G., 408
Horne, Willus M., 113
Horton, William L., 342
Houston, Karen J., 342
Jackson, John R., Jr., 342
Jagnandan, Norris R., 232
Johnson, Stephen P., 301
Jordan, Scott B., 302
Kahlon, Ravinder, 71
Karstens, Allen E., 342
Kendrick, Leland R., 302
Kent, Ronald S., 343
Lake, Mary Elizabeth, 302
Lawrence, William Keith, 302
Lincoln, Stephen R., 302
Loiacano, Dale P., 302
Lucas, Aubrey B., 343
Lucia, Helen L., 233
Lyell, Mark S., 302
Mace, James A., 342
Mann, John E., Jr., 233
Mauldin, Chris L, 302
McKellar, David L., 343
McLeod, Carroll M., 233
Merritt, Gregory W., 343
Miller, Mary C., 71
Morgan, Dennis P., 343
Norton, Timothy W., 303
Okoye, Samuel C., 408
Parker, Tammie B., 343
Parker, Waylon M., 113
Pearson, Eric J., 303
Phillips, Mark T., 343
Pierce, Lee B., 113
Ray, Linda I., 408
Renaudin, William S., 233
Rhodes, Philip G., 446
Richardson, Toni B., 446
Rigby, Joel L., 343
Robbins, Kenneth K., 343
Rushing, Eric L., 303
Ruvinsky, Ernesto D., 343
Sachitano, Richard A., 71
Salkind, Alan R., 71
Sams, John Elliot P.,446
Sauls, F. Clark, 71
Schaeffer, Philip A., 233
Schwartz, Robin H., 446
Searles, John M., Jr., 233
Secrest, Charles L., 233
Senter, Bruce S., 409
Sheffield, Eugene G., 343

Short, Valerie A., 343
Smith, Douglas N., 234
Smith, Elizabeth H., 343
Stone, Reuben H., 343
Stretch, T. Brian, 71
Summers, Jeffery T., 343
Sumrall, Dawn M., 234
Teeter, Mark D., 303
Thiel, Clara A., 234
Thomae, Dickinson, 446
Thompson, Catherine A., 71
Thompson, David M., 303
Thompson, James R., 344
Threadgill, Stephen T., 234
Trotter, Robert E., 71
Tsao, Audrey K., 344
Walton, Billy R., 72
Weed, Thomas, E., 234
Werhan, Carol F., 303
Whitehead, Kary G., 303
Willis, Gregg A., 234
Wolben, Martyn D., 303
Yanez, Dimitri A., 409
Zimmerman, Rena B., 446

Mental Illness
homelessness and chronic mental illness in Mississippi [Chawla and Griffith] *39

Mississippi State Medical Association
124th Annual Session Highlights, 220-N
124th Annual Session Ramada Renaissance Hotel, Jackson, 148-N
1992 socio-economic and legislative forum held January 21, 66-N
actions of the MSMA house of Delegates 124th Annual Session April 29 - May 3, 1992, 223-N
Central Medical Society Auxiliary adopts Blake Clinic as special project, 442-N
delegates and alternate delegates attending the 124th annual session, 225-N
Health Choice'92, 186-N
House of Delegates, 148-N
MSMA 124th Annual Session program overview, 110-N
MSMA 124th Annual Session offical call, 148-N
MSMA conducted evaluation and management coding workshops during January, 62-N
MSMA House of Delegates' non smoking resolution gets action, 62-N
MSMA members volunteer to recruit new AMA members, 337-N
new elected officers, Board and Council members, 221-N
president's pages [Waites] 20: 52; 96; 140
president's pages [Gates] 178; 216; 256; 286; 328; 362; 394;
summary of Board of Trustees Meeting December 14, 1991, 63-N
summary of Board of Trustees Meeting March 28-29, 1992, 189-N

O

Obstetrics and Gynecology
the University of Mississippi Medical Center In Vitro Fertilization Program: 1984-1991 [Sopelak et al] *275
treatment of unruptured ectopic pregnancy with Methotrexate [Issacs et al] *81

Ophthalmology
ophthalmic laser surgery; therapeutic implications for the primary physician [Cotten] *131

P

Peritoneal Lavage
grossly positive peritoneal lavage and nontherapeutic laparotomy after abdominal stab wound [Pollack et al] *313

Personals
Abangan, Roland T., 117
Abraham, George E., II, 115; 347
Achord, James L., 115
Alford, Tim, 196
Allen, Mark, 347
Allen, Paul M., 30; 237; 265; 347; 411
Allen, Samuel M., 377
Arnett, William R., 30
Avara, William Travis, III, 74
Bailey, Robert E., 265
Baggett, Horace H., 306
Bagnato, John, 447
Banquer, Kirk J., 411
Barksdale, Bryan, 447
Barnes, Robert H., 117
Barr, William M., 156
Barrett, Gene, 156; 237
Bass, Charles Patten, 347
Bateman, Kyle, 265
Beall, Mike, 347
Beam, Stephen, 411
Beeman, Kenn, 347
Bowen, Frank W., 377
Bowden, Douglas E., 347
Brandon, Leonard, 347; 411
Brandon, Steven C., 411
Brantley, Nan C., 306
Brookins-Reddix, Natalie, 449
Bryant, Edward E., 377
Bruce, James A., 347
Bullock, Ronald A., 30
Burford, Sandra F., 156; 377; 447
Burnham, W. Darrell, 306
Bush, William G., 115
Butler, Gloria Jean, 306
Butler, Harry L., 156; 411
Byers, Michael R., 306
Caillouette, R. K., 377
Campbell, Joe H., 306
Cannella, Dominic, 115
Cannon, C. Ron, 74; 237; 347; 447
Cargile, Kenneth R., 115
Carruth, Edward L., 74, 115, 196
Carstens, Neil Thomas, 306, 378
Causey, Jack Q., II, 115
Causey, William A., 196
Chase, Vernon, 306
Cheatham, David H., 30
Chmelick, John T., 411
Clark, Richard, 265
Clingan, Robert C., 411
Clippinger, David Lee, 377
Cobb, Alton B., 447
Cole, Craig, A., 411
Coleman, Michael W., 306
Conerly, D. B., 266
Crawford, Dewitt Grey, 447
Creekmore, Samuel J., 237
Dabney, Moncure, 115
Daggett, Robert B., 447
Daniel, C. Ralph, III, 30; 237; 265
Davis, Ronald Dean, 377
Das, Suman K., 447
Dilworth, Robert E., 307
Donahoe, Edgar N., Jr., 347
Downing, Deborah J., 447
Draper, Edgar, 74
Duck, E. G., 411
Duggan, Frederick T., 306
Durfey, John Joseph, 411
Dyess, Eric M., 411
Edney, Daniel Paul, 115, 377
Edwards, Joseph D., Jr., 347
Eggert, Roger A., 306
Ellis, George, 306
Ellis, Juliana, 347
Emerson, Charles W., Jr., 30
Ethridge, Chis P., 379
Evans, Robert, 347
Farina, Joseph W., Jr., 265
Feldman, Arnold E., 447
Ferguson, James V., Jr., 348
Ferguson, Mitzi, 197
Ferguson, Scott, 347
Field, Edward Dunbar, 378
Field, R. J., Jr., 30; 156; 265
Fisher, Kevin, 347
Fleetwood, Barbara A., 411
Fletcher, Gardner L., 347
Flores, Thomas R., 306
Folk, Ben P., III, 347
Ford, V. John, III, 348
Fox, H. Creed, 379
Fraser, Lionel B. Jr., 377
Freeman, Howard, 30
Fuller, James M., Jr., 447
Furr, George, 411
Gable, Gerald, 265
Gandy, Thomas H., 447
Gerald, Carolyn, 196
Giffin, Robert Lee, 378
Gillespie, James Barry, 347
Gillespie, Lamar, 265
Gilliam, L. Scott, 306
Gilliland, David H., 347
Glover, Wendell Hughes, 115
Goodman, Barbara B., 347
Gordon, James, 74
Gorton, Alice, 411
Grafton, Thomas W., 347
Graham, Robert H., 307
Graham, Ron, 115
Granger, Wesley D., 449
Green, Marion V., 348
Griffin, Brooks, 156
Guice, Charles E., 265
Haley, Charles T., 378
Halton, Joiner Mack, III, 306
Harless, Stephen L., 348
Harper, John R., 266; 306
Hartness, D. Stanley, Jr., 348
Hassell, John F., 378
Havens, Michael R., 348
Henderson, Elizabeth C., 306
Herrington, R. Glenn, 348
Herrington, Robert R., III, 74, 196
Hill, J. Edward, 348
Hill, Julian B., 196

Hirsch, Gatherine P., 196
Hitt, Kevin L., 348
Holland, John G., 306
Hoover, Jack C., 306
Horne, Mark, 115, 196
Horton, William L., 378
Howard, Martin L., Jr., 348
Huckabee, Rife Edward, 348
Hsu, Patrick, 74
Ingram, Fred H., 30
Jackson, Dan W., 348
James, Maurice, 237
Joe, David, 378
Johnson, Kurt, 306
Johnson, Stephen P., 266; 348
Johnston, Joseph E., 413
Joiner, Thomas E., 266
Jones, Leslie L, 347
Jones, Lowell, 306
Jones, Virginia Anne, 30
Jordan, Robert, 237; 266
Jordan, Scott B., 348
Kamp, Peter, 74; 347
Keady, Dwight S., Jr., 306
Kellum, William C., 306
Kendrick, Leland R., 306; 349
Kennedy, Robert A., 350
Knight, Charles L., 197
Krooss, William F., III, 237
Kuehnle, Bruce, M., 74
Lamar, Wayne T., 306; 378
Lambuth, Bruce W., 306
Lawrence, William Keith, 306
Leigh, Joe N., 306
Lewis, John William, Jr., 30
Lewis, Michael R., 413
Liddell, Hal. T., 447
Lindstrom, Eric, 115
Little, Diane, 196; 378
Little, Nelson, 413
Logan, William D., Jr., 447
Loiacano, Dale, 349
Lopez, Roberto H., 349
Lou, Anna, 447
Low, Annette K., 115
Lowery, Michael W., 307
Lucas, Aubrey B., 379
Lyell, Mark S., 307
Lyons, A. Gordon, 306
Lyons, Rebecca, 307
Lucas, John F., Jr., 347
Lucas, John F., III, 347
Luethje, Ronald, 350
Maddox, Bill, 156
Magiros, Eva, 413
Mann, John E., 196
Mansel, J. Keith, 349
Marner, Wesley, 156
Martin, Frank G., 115
Martin, Sherry A., 379
Matherne, Paul G., 74
Mathews, Christopher V., 413
Mathis, Phil, 196
Mauldin, Chris L., 349
Mayo, William S., 156
McGee, George, 447
McHenry, David G., 307
McIlwain, James S., Jr., 196
McKell, William M., Jr., 30
McKibben, Everett C., 307
McKellar, David L., 306
McLain, Patrick G., 447
McLaurin, Clyde Ray, 413
McLeod, Carroll M., 413
McMahan, Lynn, 30
McNair, Alfred E., Jr., 449
McNair, Obie M., 116
Mehta, Ursha, 266
Meyer, William, 449
Miles, Johnny F., 379
Mladineo, John P., 116
Montgomery, Tom, 197
Moore, Hal, 116
Morgan, Dennis P., 307
Morgan, Frank J., 237
Morrison, Francis, 196; 237; 266
Morrison, John, 349
Morrissette, C. Troy, 379
Mosquera, Luis Felipe, 74
Mullen, Paul E., 413
Murphy, Harriet, 116
Mutziger, John C., 266
Newcomb, Martin M., 74
Namihira, Yoshinobu, 197; 266
Nicholas, William C., 379
Nichols, A. N., 74
Nichols, Kevin, 116; 307
Northington, Monica L., 413
Norton, Timothy W., 306
O'Neal, Michael R., 411
O'Neal, Ramsay, 265
Page, Mathew, 75
Pandey, Shanti, 379
Parker, Tammie Bayne, 307
Parvin, T. Steve, 75
Patel, Rameshkumar B., 380
Patterson, W. J., 75
Payne, Joel, 116
Pearson, Eric J., 349
Pearson, Glen, 265
Peasley, Daniel J., 348
Perry, C. Stephen, 347
Phillips, Mark T., 307
Poole, Calvin P. Jr., 307
Powell, William Edwin, 116
Proctor, Barbara J., 380
Pulliam, Joe, 115; 449
Purdon, J. Steve, 413
Raulston, William, 265
Reddix, Carl M., 449
Reddix, Michael A., 449
Reed, Marion, 349
Renaudin, Rudolph S., 157
Reynolds, Denise W., 306
Richardson, Toni B., 349
Rigby, Joel L., 349
Ritter, Robert, 31
Robbins, Kenny K., 307
Rose, Walter, 75
Rudeen, Don, 237
Runnels, Rudolph S., 157
Salloum, Joseph, 347
Sanders, C. J., 349
Sanford, Ben, 347
Sangani, Bharat, 31
Sauls, F. Clark, 31, 449
Saulters, Robert L., 449
Savoie, Buddy, 75; 116; 197
Schwartz, Robin H., 349
Searles, John M., Jr., 266
Secrest, Charles L., 350
Selmon, Francis, 266
Senter, Bruce S., 308
Senter, John M, 350
Scott-Conner, Carol, 197
Shappley, Nathan P., 447
Shaw, Fredrick C., 197
Shidler, Merrill J., 449
Shirley, Stephen M., 115; 347
Shrock, Michael B., 350
Shrock, Wirt G., Jr., 197
Siefker, Joseph D., 449
Simpson, Tommy, 449
Slater, Craig M., 116
Sledge, C. Chapman, 197
Smith, Bobby D., 306
Smith, Douglas N., 266
Smith, Robert, 267
Sneed, Ralph, 31
Snyder, Maurice E., 116
Spencer, David L., 157
Stagg, Stephen W., 197
Starnes, Eddie C., 75, 380
Stephens, James O., 197
Stogner, Steven W., 308
Stone, Harper, 350
Strong, William B. Jr., 306
Sumrall, Dawn, 197
Tarsi, Mary Ann Frank, 116
Tatum, Fred, 265
Taylor, Eugene E., 380
Tennyson, Wendy R., 31
Terry, Joe, III, 380
Thaggard, Lamar, 237
Thigpen, J. Tate, 116
Thomas, Douglas F., 449
Thomas, Stephen R., 116
Thompson, Allen H., 347
Thompson, David M., 350
Thompson, Ed, 267
Thompson, William P., 31
Tinsley, Plez, Jr., 31
Tribble, Anita, 197
Triplett, Laramie C., 238
Turnbull, Edward R., 31
Turner, Gerald, 380
Turner, William S., 347
Ugajin, Kazuo, 117
Vaughan, William H. Jr., 308
Velasco, Diego, 197
Veerisetty, Indira Kota, 449
Waites, James C., 238
Wallace, Mickey P., 308
Ward, E. Fraizer, III, 117
Weaver, Michael, 380
Weed, Thomas H., 117
Wells, Willie Lee, 31
Wender, David F., 197
Whitaker, Murray, 238
White, John J., 117; 157
Whitehead, Kary G., 308
Wilkes, Thurston E., II, 350
Wilkins, Louis F., 75
Williams, Steven C., 348

Willis, Gregg A., 350
Wisner, Winfred, 31
Woleben, Martyn, 308
Wright, Tim, 413
Wyble, Eric, 117;
Yanez, Dimitri A., 380
Yerger, Buford, 197
Primary Care
accessibility to primary care in Mississippi, [Ladner, Blake and Replogle] *245
primary care physicians in Mississippi: implications for rural health care [Boyd and Bross] *165

R

Radiology
evaluation of mamographic calcification [Flowers and Launey]*319
evaluation of Mamographic stellate lesions [Flowers and Powers]*359

S

Sinusitis
diagnosis and management of sinusitis in children [Wallace] *45
Spine
traumatic neuropathic spinal arthropathy [Montgomery and McGuire] *209

U

UMC
clinical pharmacists study new drug, 192-N
Doctors' Day observed, 193-N
Dr. Eichhorn represents United States on anesthesia task force, 374-N
Dr. Evers Transfered to rehabilitation center, 192-N
Dr. Francis Morrison lectures in Buenos Aires, Argentina, 404-N
Dr. Guyton Receives Award, 339-N
Dr. O'Connell Serves as Society President, 340-N
Dr. Philip Merideth named 1992 AMA/Burroughs Wellcome Fellow, 298-N
electronic bulletin board and library services available through MisHin at UMC, 262-N
faculty appointments at UMC, 24-N; 261-N; 339-N
Gurich recognized at UMC, 262-N
Harvey Mason attends ACS clinical congress, 405-N
Mark Wall named director of UMC Medical Pavilion, 298-N
professorship at UMC honoring Dr. Ralph T. Wicker, 373-N
study participants needed, 192-N
UMC HIV clinic, 193-N
UMC students receive Hearin-Hess Scholarships, 374-N
UMC students receive Ottilie Schillig Memorial Scholarships, 375-N

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears as as follows: "A," Abstract; "C," Comment; "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "D," Delegates Report; "RS," Radiological Seminar; "ME," Medical Ehtics; "BR," Book Review: "AP," Auxiliary Page; "S," Special Article; the asterisk (*) indicates an original article in the Journal.

A

Abraham, George, 97-E; 217-E; 435-E

B

Bagnato, V. John, *249
Barrett, Gene R., *279
Blake, Gregory H., *245
Boyd, Ronnie, *165
Bross, Michael H., *165

C

Cannon, C. Ron, *1
Chawla, Anwant, *39
Clay, Bryan M., *1
Cotten, Milam S., *131
Cowan, Bryan D., *81; *203; *275

D

Dabney, W. Moncure, 141-C; 435-E

E

Evers, Jan, 218-L

F

Field, Richard J., Jr., *423
Field, Richard J, III, * 423
Flowers, W. Mel., Jr., *319; *355;
Forbes, Robert C., *171
Fox, Michael D., *203
Fyke, F. Earl, III, *385

G

Gates, William C., 178-PP; 216-PP; 256-PP; 286-PP; 328-PP; 362-E; 394-PP; 434-PP
Gough, Walter C., 288-L
Griffith, James L., *39
Griswold, John A., *313

H

Haley, Nancy J., *87
Hampton, Harriette L., *81
Harris, Randall E., *87
Henderson, Elizabeth C., 55-L
Hopkins, Donald A., 54-L

I

Isaacs, John, *81

J

Jenkins, Rod, 397-L
Johnston, Joseph E., 53-E; 97-E; 179-E; 287-E; 329-E; 395-E
Jorden, Robert C., *313
Jutras, Mark L., *275

K

King, Brian, 257-L

L

Ladner, Mark, *245
Launey, Donna S., *319
Lockey, Myron W., 21-E; 141-E; 363-E
Lowery, Will, 365-L
Long, Cecil A., *81; *275

M

McGehee, Ramon P., *81; *203; *355
McGuire, Robert A., *209
Meeks, G. Rodney, *81; *203; *355
Milhorn, H. Thomas, Jr., *123
Montgomery, Thomas J., *209
Morgan, Frank J., Jr., MD, 323-S
Muscat, Joshua E., *87

P

Parks, Sue Y., * 423
Patel, Rameshkumar B., MD, *355
Pollack, Charles V., Jr., MA, MD, *313
Poole, Galen V., MD, *313
Powers, Cynthia I., *359

R

Reid, Elaine, *279
Replogle, William, *245
Rivlin, Michel E., *81; *355
Rose, Jean Marie, *279

S

Salloum, Joseph, *5
Smith, Perrin N., *330
Sopelak, Victoria, M., *275
South, Dwalia, 183-L

W

Waites, James C., 20-PP; 52-PP; 96-PP; 140-PP; 213-S
Wallace, Mickey P., *45
Walley, Elizabeth, *171
Wetherbee, Helen, JD, MPH, 365-L
Wilson, Joe Perkins, *1
Wynder, Ernest L., *87

TABLE OF PAGES

January	1 to 38	July	245 to 274
February	39 to 80	August	275 to 312
March	81 to 122	September	313 to 354
April	123 to 164	October	354 to 384
May	165 to 202	November	385 to 422
June	202 to 244	December	423 to 460

Placement Service

IMMEDIATE OPENING FOR FULL-TIME ER PHYSICIAN in Greenwood, MS. Average 42 hrs/wk with salary range $160,000 - $175,000 depending upon experience. Additional work available if desired. Double coverage during peak hours and malpractice provided. Contact Jeff Moses: 455-2008 after 5 or mail to 410 Crockett, Greenwood, MS.

MISSISSIPPI; GENERAL SURGERY- Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice w/coverage from surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician $150,000 net before taxes for 2 years. Wanda Parker 800-221-4762.

FP, IM, OB, GS, Peds, ER needed in one of North Mississippi's fastest growing areas. Location less than one (1) hour from Memphis with a drawing area of over 30,000. Incentive package available. Contact Richard Manning, South Panola Community Hospital, P.O. Box 433, Batesville, MS 38606. 601-563-5611.

Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

Physician Specialist in Emergency Medicine, Episodic Care, and Industrial Medicine

MEA (Mississippi Emergency Association, P.A.) is on the forefront in Mississippi in Emergency, Episodic, and Industrial Medicine. We are a local progressive group of board certified, professional, full-time physicians organized as a wholly owned and managed business.

MEA MEMBERSHIP OFFERS A PHYSICIAN:

- Ownership Opportunities
- Profit Sharing Plan
- CME Allowance
- Professional Membership Allowances
- Disability Income Protection
- Health Insurance
- Life Insurance
- Malpractice and Reporting Endorsement Coverage
- Vacation Allowances

If you would like to know what career opportunities we can offer you, send your CV to Sheila M. Harkins or call (601) 366-6503 or 1-800-844-6503.

MISSISSIPPI EMERGENCY ASSOCIATION, P.A.
P.O. Box 13849; Jackson, Mississippi 39236-3849;
(601)366-6503 or 1-800-844-6503

FAMILY PRACTICE/ ER PHYSICIANS NEEDED FOR FILL-IN OR REGULAR PART-TIME BASIS AT A NORTH EAST JACKSON CLINIC. CALL 957-2273.

Emergency room physicians wanted. Six hospital contracts in northeast Mississippi. Salary ranges $90,000 to $150,000 plus health insurance, life insurance, malpractice insurance, moving expenses. Call (601) 328-8385.

IMMEDIATE !!!!! opening
for the right person.

If you are a **FAMILY PRACTITIONER** and are looking to have a more quality living & working environment with a **NET INCOME GUARANTEE** for the first year, take a look at what we can offer you!

Local hospital part of 16 hospital system, fully staffed and financially stable. Located between 2 recognized hospitals, in active community, with growing young families & stable economy experiencing a steady increase over the last 10 years. Fully equipped facility, offering practice support and excellent referral base.

State recognized under served area offering added income potential. For a confidential inquiry, contact **DONNA LANE, 800-362-5396, or FAX CV to 404/977-6518.**

MOONLIGHTING IN MISSISSIPPI



SINCE 1977, PRI-MED HAS BEEN STAFFING EMERGENCY DEPARTMENTS IN MISSISSIPPI, ARKANSAS, TENNESSEE, AND CALIFORNIA. PRI-MED OFFERS A WIDE RANGE OF OPPORTUNITIES FOR THE PHYSICIAN, FROM THE OCCASIONAL NIGHT SHIFT TO THE FULL-TIME EMERGENCY ROOM DIRECTORSHIP. FOR MORE INFORMATION ON MOONLIGHTING IN YOUR AREA PLEASE CALL JOE PAT JUNKIN OR PATSY MCDANIEL AT:

1-800-821-6382 - OUTSIDE TENNESSEE
1-901-685-9305 - IN TENNESSEE

Equal Opportunity Employer

PRI-MED
primary medicine

6263 POPLAR AVENUE, SUITE 700 • MEMPHIS, TENNESSEE 38119

EM, FP, GP, GS, IM, PD, OB, ORS needed in Alabama, the Southeast, and nation-wide. Please send CV to PO Box 70910, Tuscaloosa, AL 35407, or call 800-543-6050.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; Martina Mayfield (ext. 2276).

The Mississippi DDS is recruiting physicians for part-time employment in the Jackson Office. Job requires review of medical reports for determination of benefit eligibility under Social Security criteria. Board certified/eligible psychiatrists, pediatricians, pulmonologists, cardiologist and neurologists are needed. Flexible work schedules. For information contact Deborah Warriner at 601-923-2153.

Disability Determination Services
1-800-962-2230

COMMENTS or QUERIES .....

The Editors of *Journal MSMA* invite you to comment on any material that appears in or is absent from the publication. If you have a query or comment, please sent it to:

The Editor, *Journal MSMA*,
PO Box 5229,
Jackson, MS 39296-5229.

Classified

Medical Laboratory Equipment For Sale : Hycell Counter 555 with Hct and MCV $1,000.00, Stat-Test System for glucose, pot, chol, & hgb $250.00, Junior Angle model 1600 centrifuge $150.00, #100 incubator $50.00. Call 601• 287-1453 or 601• 287-1202.

MEDICAL EQUIPMENT FOR SALE: Retlotron Chemistry Analyzer - Finger Stick Whole Blood. 3-5 minute results for Glucose, Cholesterol, Uric Acid, Amylase, SGPT, SGOT, Triglycerides, Hgb, BUN, GGT, Potassium, $1,000.00. **Call 601-483-5353.**

Medical clinic for a 1 to 3 physician occupancy. Equipped with supplies, furniture and instruments probably sufficient to institute immediate practice. Includes patient waiting area, 3 business offices, 9 examination rooms, 3 treatment rooms, lab, x-ray, staff lounge and storage rooms. **Located in downtown Moss Point**, an industrial city of 17837, with 2 rivers, Interstate 10 and airport within city limits. Adjacent to post office, banks, pharmacy. Ample parking. Convenient to Singing River Hospital. Contact Mrs. Barrett at John Jones and Associates. 1-800-748-8650.

Items for the
Placement & Classified Sections
should be sent to the
Editors, *Journal MSMA*,
PO Box 5229, Jackson, MS 39296-5229.

The advertising rate is $2.00 per line or $75.00 per 1/4 page block.
Rate cards available upon request.

Index to Advertisers

CancerPay Plus 5
CompHealth 437
CompuMed 444

Deposit Guaranty Investments ..... **third cover**
Disability Determination 459

Eli Lilly & Co. - Humulin 433
Employer Plus, Inc. 448

Medical Assurance Co. of MS 450
Medley & Company 437
MS Association for Home Care 438
MS Comprehensive Health Insurance Risk Pool Association **8**
MS Emergency Association 458
MS Methodist Rehabilitation Center ..... **second cover**
MS Physicians Insurance Company 451
MSMA Benefit Plan & Trust ..... **fourth cover**

Premier Printing 445
PRI-MED, Inc. 459

The Doctors' Company 4
Trustmark 445

US Air Force 441
US Army Active 432
US Army Reserve 446

LIBRARY
Medicine



GONE ARE THE DAYS OF EXCESS.

OF FREE WHEELING. OF WINNING AT ALL COSTS. OF SEEING JUST HOW FAR YOU CAN GO AND JUST HOW MUCH IS TOO MUCH. THERE IS TIGHTER REGULATION. INVESTMENT FIRMS ARE REASSESSING, GOING BACK TO SQUARE ONE. THE POINT IS, INVESTING TODAY IS SERIOUS BUSINESS. AND IT IS SERIOUS BUSINESS AT DEPOSIT GUARANTY INVESTMENTS. NOT TO SAY WE'RE SO CONSERVATIVE WE DON'T SEIZE AN OPPORTUNITY WHEN IT COMES ALONG. IT'S THAT WE PRIDE OURSELVES ON ADVISING OUR CLIENTS BASED ON SOLID RESEARCH, AND ON MAKING LEVEL-HEADED DECISIONS. (NO HASTILY-MADE RECOMMENDATIONS HERE). SO FAR IT HAS PROVEN SUCCESSFUL. TODAY, WHILE THE REST OF THE FINANCIAL WORLD SEEMS TO BE TAKING A STEP BACK, WE ARE PROUDLY TAKING TWO FORWARD. WE'VE EXPANDED OUR INVESTMENT STAFF TO GIVE OUR CLIENTS BETTER SERVICE. WE'VE CONSOLIDATED OUR VARIOUS INVESTMENT OUTLETS INTO ONE PROFESSIONAL INVESTMENT FIRM, TO GIVE OUR CLIENTS ADDED CONVENIENCE WITH VERY COMPETITIVE COMMISSION RATES. LOOK TO US AS AN INVESTMENT FIRM WITH INTEGRITY. ONE THAT IS A TRUSTWORTHY, LOYAL FRIEND TO THOUSANDS OF INVESTMENT-MINDED MISSISSIPPIANS. AND REST ASSURED, WE OFFER THE SAME SERVICES AS MORE WELL-KNOWN WALL STREET FIRMS. PLEASE PHONE US AT YOUR EARLIEST CONVENIENCE.

DEPOSIT GUARANTY® INVESTMENTS

MEMBER NATIONAL ASSOCIATION OF SECURITIES DEALERS • A FULL-SERVICE INVESTMENT AND SECURITIES FIRM • 1-800-748-9991

SIPC

You're a Professional.

You need Professional Health Insurance Coverage.

N.Y. ACADEMY OF MED
2E E 103RD ST
NEW YORK NY 10029-5207

MSMA

Benefit Plan and Trust

MSMA Benefit Plan and Trust is a superior insurance program which fulfills the quality of coverage and affordability that everyone wants.

Sponsored by the Mississippi State Medical Association, the MSMA Benefit Plan and Trust offers life and health benefits to physician members of MSMA,their employees and families.

- $1,000,000 lifetime benefits.
- Life Coverage up to $50,000.
- Broad benefits with fair and equitable rates.
- Management by and for physicians.
- Non-profit and administered at lowest possible cost.

For Complete Description of Benefits Write:

MSMA Benefit Plan and Trust
P.O. Box 55509
Jackson, MS 39296-5509

THE NEW YORK ACADEMY
OF MEDICINE

This BOOK
is NOT to be REMOVED
from the LIBRARY

NEW YORK ACADEMY OF MEDICINE
3 0681 0130971 1